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ORIGINAL ARTICLES.

BACTERIOLOGY IN MIDWIFERY, AND PROPHYLAXIS OF PUERPERAL FEVERS.*

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Each and every day brings the thoughtful and careful physician more and more to face the fact that the scientific world is still progressing, and he who keeps apace with the literature of medicine must acknowledge the fact, as proven by bacteriological investigations, that the various forms of micro-organisms are the prime factors in the causation of a large majority of the diseases in the human family. The last decade has shown, through the efforts of Pasteur, Koch, Sternberg, Vaughn, Welch and many others, wonderful progress in this branch of medical science. Many new truths have been discovered and there are still many more to be sought. The advancement already made makes it the duty of every physician to give more than ordinary attention to this subject. With our standard works on bacteriology and a good microscope, we are able in many cases to make an early and correct diagnosis. This is especially important in tuberculosis, in which it enables us to adopt early and efficient treatment,

While the minute details and the discovery of these micro-organisms are not essential for the successful practice of midwifery, yet I do claim that we should have a thorough knowledge of the nature of those germs which are instrumental in the causation of puerperal fevers.

There is a great plea for scientific ob-

stetrics, but scientific obstetrics is not complete without a thorough knowledge of bacteriology.

Sternberg says:—"Recent researches indicate that infection by streptococcus pyogenes through the endometrium is the usual cause of *puerperal fever*. Thus Clivio and Monti demonstrated its presence in five cases of puerperal peritonitis. Czerniewski found it in the lochia of a large number of women suffering from puerperal fever, but in the lochia of fifty-seven healthy puerperal women he was able to find it only once. In ten fatal cases he found it in every instance, both in the lochial discharge during life and in the organs after death. Widal carefully studied a series of sixteen cases and arrived at the conclusion that this was the micro-organism in all. Bumm and other observers have given similar evidence. Eiselsberg and Emmerich have succeeded in demonstrating the presence of the streptococcus in hospital wards containing cases of erysipelas. That puerperal fever may result from infection through the accoucheur, when he has previously been in contact with cases of erysipelas, has long been taught, and, in view of the facts above recorded, is not difficult to understand. But in view of the fact that the streptococcus of pus has been found in vaginal mucus and in the buccal and nasal secretions of healthy persons, it may appear

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strange that more cases of puerperal fever not traceable to infection from erysipelas or from preceding cases do not occur more frequently. This is probably largely due to an attenuation of the pathogenic power of the streptococcus when it leads a saprophytic existence."

According to the teaching of Welch, which is in line with that of Sternberg, the class of micro-organisms chiefly concerned in the etiology of acute ulcerative endocarditis, meningitis, erysipelas, pyemia, septicæmia, osteomyelitis, puerperal fevers, other septic and localized inflammatory affections and in general, the infection of wounds, embrace the somewhat heterogeneous group called pyogenic bacteria, of which the staphylococcus and streptococcus are the leading but not the sole representatives.

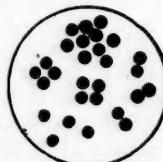
During the past three months I have made investigations in a number of healthy puerperal women, but was unable to find any of the pyogenic bacteria in the local discharge.

The fact that they are sometimes found in healthy puerperal woman does not prove that they are not the cause, for they are so widely distributed in nature, and found on healthy mucous membranes, waiting for some local lesion whereby they may cause septic infection.

Fig. 1.

STREPTOCOCCUS P.
Mag. 2000 Diam.

Fig. 2.

STAPHYLOCOCCUS.
Mag. 3000 Diam.

As these two micrococci, the streptococcus and staphylococcus, are often associated with each other and are similar in many respects, they will be considered in part together. They are both facultative parasites and are very common in suppurative processes generally. They are also common and widely distributed saprophytes which find the conditions necessary for their existence on the external surface of the human body, and of moist mucous membranes. They have been found upon the skin; in the secretions of the mouth, nose, and throat; in cultures from dirt beneath the fingernails

of healthy persons; and in the dust of occupied apartments. Both of them grow, either in the presence or absence of oxygen, hence are called facultative anaerobics. They stain readily with the basic aniline colors or methyl violet.

The streptococcus (Fig. 1) is the most important micro-organism under consideration. They are spherical in form, grow by binary division in one direction only, forming chains, and have a mean diameter of $\frac{1}{3500}$ of an inch. They multiply freely at ordinary room temperature, 60 to 70 degrees F., but more rapidly at blood heat. Thermal death-point, 130 degrees F. with ten minutes exposure. Its peculiarity is to extend rapidly along the lymph spaces and lymphatic vessels, thus causing progressive phlegmonous inflammation.

According to recent investigations mercuric chloride solution, 1: 2500, destroys vitality in two hours, and 1: 30,000 restrains development; carbolic acid 1: 300 destroys vitality in two hours, and 1: 800 restrains development; creolin 1: 130 destroys vitality in two hours; and boracic acid solution 1: 143 restrains development.

The staphylococcus aureus is shown in figure 2. They are spherical in form; with a mean diameter of $\frac{1}{3500}$ of an inch; are arranged singly, in pairs, in groups of four, and in irregular groups, and multiply rapidly at a temperature of 65 to 70 degrees F., but more rapidly at blood-heat. Thermal death-point, 140 degrees F. with ten minutes exposure.

This micrococcus differs from the streptococcus in the respect that it is not so apt to spread, but is found in furuncles, carbuncles, and various local abscesses; hence is the most common pyogenic micro-organism. Mercuric chloride solution, 1: 2500, destroys vitality in two hours, and 1: 80,000 restrains development; carbolic acid 1: 125 destroys vitality in two hours, 1: 800 restrains development; and boracic acid solution 1: 30 destroys vitality in two hours, and 1: 327 restrains development.

The staphylococcus has been considered, not because it is thought to be the cause of puerperal fever, but because of its similarity and intimate relation to the streptococcus; yet while the researches as given by Sternberg in his work on Bacteriology are still in line with the re-

searches of the present day, and the streptococcus pyogenes is still held to be the principle micro-organism causing puerperal fever, it is possible that the staphylococcus aureus has something to do with some of the milder cases of puerperal fever.

Experiments have shown that when the staphylococcus aureus is injected in sufficient quantity into the peritoneal cavity of some of the lower animals, it sets up fatal peritonitis, death taking place in a few days; and, what is true of this germ, is also true of the bacillus coli communis and the proteus vulgaris when they get into the peritoneal cavity, either from perforation of the bowels or some other source.

Good authority says that death may occur from the rapid absorption of a chemical poison developed in putrefying material, the decomposition of which is due to the "bacterium termo," and as this putrefying fluid is a good medium for the development of other life-destroying micro-organisms, the offensive odor should serve as a warning, in which case thorough antisepsis should be secured.

Lusk says: "In cases, however, where puerperal fever has a distinct period of invasion, and progresses step by step to a fatal ending, bacteria are always found invading the genital canal, and that the co-existence of blood-poison with the local lesion is an essential feature of puerperal fever." This lesion is usually of the endometrium, but it may be an abrasion of the vaginal mucous membrane, or a laceration of the cervix, and in rare cases they pass by the Fallopian tubes to the peritoneal cavity and excite salpingitis and peritonitis.

PROPHYLAXIS.

In the consideration of the prophylaxis of puerperal fever, we must realize the fact that the faithful practice of aseptic and antiseptic precautions greatly lightens the burden of responsibility that the practitioner of obstetrics must carry, yet his efforts are many times thwarted by ignorant and meddlesome persons.

We will discuss this part under three heads:

(1). Prevent the introduction of germs.—Different lying-in hospitals have adopted various sets of rules for the pre-

vention of sepsis in the practice of midwifery.

The object of this paper is to give a few suggestions relative to the prevention of sepsis in private practice, as it differs very much from that which it is possible to carry out in hospitals. All agree that the attending physician should exercise the most scrupulous care in regard to personal cleanliness and disinfection, especially of hands, finger-nails, clothing and instruments. Before making a vaginal examination the hands and finger-nails should be well washed and scrubbed and then dipped in a solution of mercuric chloride 1:1000. The fingers should then be annointed with plain or camphorated vaseline. All instruments used should be thoroughly disinfected the same as before using them about a wound in surgery.

The use of the vaginal disinfectant douche at the onset of labor is still an unsettled question. Some use it and others do not. Should you arrive in time and wish to use it, first bathe the external genitals with a solution of mercuric chloride 1: 2000, then give the vaginal injection of a one to two per cent. solution of creolin, which is preferable to mercuric chloride for this purpose, as it is a lubricant as well as an antiseptic. Mercuric chloride is astringent and facilitates laceration. The vaginal douche of warm sterilized water continued daily during the last two months of gestation I believe to be beneficial, and I have never seen any ill effects from its use.

In regard to the use of the vaginal douche after labor, it is not approved of by a large number of physicians at the present day; but its use has strong followers on every hand. Galabin gives a simple post-partum irrigation of mercuric chloride 1: 3000, but during the entire puerperal period he uses two to two and one-half per cent. solution of carbolic acid. In uncomplicated, unprotracted cases of labor, the daily use of the douche of simple warm sterilized water is usually sufficient, provided the genitals are first bathed with sterilized water or some disinfectant solution, I believe that the thorough bathing of the lochial discharge from the genitals, at least twice a day, is of more importance than the vaginal douche. I have used this alone in several cases and find that when the bed-linen, clothing, etc., are unsmeared there is scarce-

ly any odor when at the bedside, and the patients seem to do as well as when both are used. I occasionally find some difficulty in getting the average nurse to use the water in bathing the genitals, as some of them still think that not a drop of water must touch the patient until after the ninth day; but when you explain to the nurse its object, with instructions that they should be wiped thoroughly dry, your directions are usually followed. I find the absorbent pad for taking up the lochial discharge answers every purpose when made of several thicknesses of cheese-cloth which should be changed at least twice a day. Absorbent cotton may be inserted between the layers of the cheese-cloth.

The importance of good ventilation should not be forgotten, as it is a very efficient means of limiting the number of pyogenic bacteria and other noxious exhalations so common in occupied apartments. The lying-in room should be the largest and most pleasant in the house.

Good light is also beneficial. Day-light, and better still direct sunlight, is a powerful destroyer of many bacteria.

(2). Destroy the action of these germs. Remedial measures under this head will be considered in complicated cases, and when labor has been protracted, giving rise to probable laceration of the cervix, or of the vaginal mucous membrane; and, also, when the lochia becomes of an offensive odor after careful attention has been given to cleanliness and bathing the genitals. It is in these classes of cases that there is danger of sepsis, and in these the intra-vaginal douche should be used once or twice daily, as the case demands, of carbolic acid two per cent, or creolin two per cent; and, if mercuric chloride is used, it should be as strong as 1: 2000.

When these antiseptics are reduced materially in strength from that recommended, they fail to accomplish their purpose and merely act in partially washing away any micro-organisms that may be present and retarding the development for a time of those left *in situ*.

When the bad odor of the lochia is not controlled by using the douche, and it is found to come from the uterus, the advisability of using the curette and intra-uterine douche should be considered.

At the New York Post-Graduate School and Hospital they have adopted the following rules:

"An ante-operation douche should be given before any procedure, and an intra-uterine post-partum douche after instruments or hands have been in uterus, of carbolic acid three per cent. or creolin one per cent."

"Mercuric chloride 1: 1000 is used for hands and bathing genitals."

"N. B. No mercuric chloride is used in the parturient canal."

"No ante-partum nor post-partum douche shall be given without cause."

The strength as given by Sternberg of the following germicides may be used as a douche without doing harm to the vaginal mucous membrane: mercuric chloride, 1: 1000; carbolic acid, 1: 50; crelin, 1: 50; boracic acid, saturated solution.

(3). Shut up the doors—veins, lymphatics and Fallopian tubes. This is to be done by using suitable means for maintaining uterine contraction.

Lusk says: "In the puerperal period the warm carbolized douche stimulates uterine retraction."

While I do not think much of the binder for the purpose it is usually applied, it certainly gives comfort in many cases; and, when put on firmly for the first five to ten hours in cases of uterine inertia, it maintains intra-abdominal pressure, causes the after-pains to quiet down more readily, and is thought to prevent flooding. When this uterine inertia is due to depression of the vital forces, quinine, in moderate doses, becomes a valuable stimulant.

In the treatment of severe post-partum hemorrhage caused by uterine atony, the fundus should be pressed with one hand, with the other hand clear away all clots and give a hot intra-uterine douche. Ergotine may be given by hypodermatic injection.

I speak of these means of preventing the loss of blood because of its importance to the subject before us, as anemia induced by hemorrhage is said to increase the susceptibility to septic infection, hence the loss of blood should be reduced to a minimum.

It has been my purpose in this paper to be as brief as possible in presenting the foregoing important measures, many of which may not be new, but if they are strictly followed in the management of obstetrical cases, the mortality may be reduced to a small percentage and the practice of midwifery be both easier and more successful.

THE THERAPEUTIC DIFFERENTIATIONS OF ACUTE AND CHRONIC DISEASES.

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A little over forty years ago, armed with the knowledge implied by a university medical degree, and fortified by the standard text books of the day, Watson, Wood, and the reference books of Copland, I started out in the avocation of trying to subdue disease. I can recall instances in my early efforts that brought me credit in the management of acute diseases, and not a very few humiliating defeats in the treatment of chronic ones. In some of the latter I was in not a few instances worsted by empirics, and by some nostrum remedies. Thinking that my diagnosis of the disorder must have been incorrect, a careful reading of authorities usually verified the accuracy of my diagnosis as well as the correctness of the treatment according to the standards. Finding that such an outcome in the treatment of chronic maladies by other physicians was by no means uncommon; that some skepticism of the healing art, and especially of scientific methods over empirical ones in lingering diseases, should have arisen, is what might be expected according to the ordinary rules of evidence. So a determination arose and became a ruling motive of my life to fathom the causes of the failures brought upon me by those whose knowledge of the elements of medicine, such as anatomy, physiology and pathology, were beneath contempt; and since that time a large part of my leisure hours has been devoted to the solution of the causes of my failures.

This led me into the study of etiology and hygiene, the latter a subject far too much over-looked by physicians in its bearings upon the production of disease and the restoration of health. Especially has a good conception of the first four laws of health enabled me to guide aright the sufferers from chronic maladies so that their health might be fully restored. For, bear in mind that the condition of the chronic invalid is not like that of one suffering by an acute disease; he is not confined to one room, or to indoor life; he takes his three meals a day more or less heartily; he is not kept between sheets day and night alike, but resumes his cloth-

ing each day; he is not deprived of exercise and the glorious light of sunshine like the acute sufferer in his darkened apartment.

In the management of acute diseases, both medical and lay attendants pay strict attention to the observance of a correct diet; very different is the ordinary routine during the treatment of a chronic derangement. If the victims have good appetites they are left pretty much to follow their discretion as to how much or what they ought to eat and drink; as to the manner and times of it, they are seldom thought of, much less mentioned.

Patients thus left to follow their own whims and caprices are allowed, while in a weak state, to try experiments on themselves, usually very painful ones, as to what is good for them, and what is not; information which the medical attendant should have furnished them in advance. Far too commonly the physicians' directions as to diet in chronic maladies are not specific, but vague and general, or are alluded to in a very languid and careless manner, so that the patients rightly conclude that very little importance is to be attached to them. Hence the observance of dietary rules, even in digestive derangements, is of the careless and fitful kind, and is apt to be worse in its selections than the physician intended. The inquiry often made of those who have long suffered under digestive and hepatic disorders in which a proper diet is often of supreme importance, as to what regulations the previous attendant had imposed, elicits the all but uniform response that they were told to be a little more careful than ordinary—whatever this may mean. Such an inculcation virtually concedes that the patient knows just about as much as the physician what is best for a sick man to eat, whether or not this be a slice or two of fried bacon, eaten with refined flour bread steaming hot from the oven, imperfectly masticated and hastened onward to the stomach with mouthfuls of tea or coffee, supplemented by a section or two of pie or of sweet cake at each meal.

Now as observation has made it clearly

apparent that the largest number of digestive and hepatic derangements are the products of errors in diet, it follows by the simplest rules of logic that if the cause be continuous, so also will be the effects. Yet in the face of this truism, many physicians only seek to remove a jarring dissonance in the machinery of life by the application of more and more medical oil, rather than by removing the cause on which dissonance depends.

The question of exercise is a very important one for those laboring under a chronic malady, as it involves the bringing to bear of a very active agent to restoration. Granting this is equivalent to admitting that the lines of treatment for this class of diseases are wholly different from and inapplicable to the acute.

The therapeutical benefit to be derived from regular exercise by those laboring under chronic maladies, seems to call for freshening up in the physicians mind, judging by the frequency of its neglect and the almost exclusive reliance on drugs to effect their removal. Nor is this mode of dealing with lingering diseases confined to a practitioner here and there. I have just looked into a standard text-book which is doubtless a guide to thousands, in which the nearest approach to recommending exercise as an aid to the cure of dyspepsia, is to travel. Much sounder was the advice of the celebrated Abernathy to a nobleman laboring under that ailment, "Earn a shilling a day and live on it." The cogency of this advice will be perceived when the effects of exercise are correctly pictured in the mind. It accelerates the circulation and nutrition of the tissues, enhances the building up of the new, and promotes the removal of the old and effete; thereby communicating renewed energy to all the functions, creating a desire for food with an ability to digest and assimilate and use it up morphologically. At the same time it exalts the functions of the nerve cells, gives impetus to the flow of this subtle force and begets the necessity, desire and certitude of good periodical rest and sleep.

Man draws his clothing and sustenance, not from his immediate surroundings alone, like the animal world, but from all the latitudes and longitudes of the earth, yet, although the wisest of all mundane beings and at the same time the most commanding and powerful, he is the sickliest

of them all. And why? Simply because he neither knows or obeys the Ten Laws of Health. Barring inheritance and atavism, which can in time be obviated just as they can be originated when their productive factors are known, and accidents, of which the writer is a sample, all the disabilities ordinarily attributed to divine wrath, are avoidable, and they are not only avoidable but, with fewer exceptions than the fingers of a hand, curable.

I have often wondered at the skepticism of some physicians as to the power to cure. I know of no field equal to that of chronic maladies to convert unbelievers. Even the sources of fallacy that belong to the management of an acute disease are eliminated in the chronic. The elements of the contest are simple, fair and open to no deceit or mistake. Here, for example, is the case of Mr. X., Y. or Z., plain to every eye-in open court so to speak. Dr. A, B, C and the *vis medicatrix naturæ*, after fair trials have failed to cure. The same person with the same disease is presented successively to each of these physicians as well as to the let alone method, and yet the lingering malady persists as before. But no sooner does Dr. D put his hand to the case than there is a prompt change for the better, which goes to complete and lasting success. Surely when this can be done, and is done for scores and hundreds of cases, all the needful evidence of ability to cure is furnished and which no one can decry or invalidate.

My old instructor, Professor Dickson, of the University of the City of New York, made a remark that I have often thought of, to-wit: "That acute diseases should be treated acutely, and chronic ones chronically." I know of no work nor any teacher of medicine that elaborates therapeutically and in detail, this injunction. More than ever am I daily assured of its truth and importance, and that the success that irregulars now and then attain to depends upon the use of remedies that do not overmuch disturb physiological function in the management of obstinate chronic maladies. Formerly it was a common query by applicants for treatment, "Doctor how long will you lay me up under your treatment before I can go about again?" My answer almost invariably is, "Not a day, but that day by day under the use of remedies that will

correct disordered functions, you will feel better and better until complete relief is afforded."

Very rarely it is needful in chronic affections to make use of what a distinguished Professor called the *lions* of the *materia medica*, but almost invariably of the *lambs*—gentle, but sufficient to bring an deficient function up to the healthy standard and hold it there until sufficient tone and strength are acquired for the organ to run the function normally by itself. In the management of all chronic diseases it is seldom needful to disturb the healthy organs by strong medication, and never by remedies that will lurk in the system and produce as much harm, almost, as did the disease for which they were administered.

For nearly all lingering diseases the fluid or solid extracts are to be preferred, if prepared by a reliable pharmacist. If an habitual hepatic torpor and constipation is indicated, give euonymus or stillingia, combined, when the stomach is weak, with extract of gentian and Trommer's extract of malt, or, if of a neurasthenic type, with extract of celery or cypripedium. If mercurials are indicated only the mildest should be used, and then only for a short time and at bed time exclusively, with sufficient aloin to carry them off through the large intestine mildly on the ensuing morning.

In short, over medication is a crying evil in chronic ailments. The usual report of patients after such a course is that, "the medicine helped me, but soon after I was quite as bad as ever." By laying aside all the active armamentarium in the treatment of acute maladies, and resorting to the vegetable extracts that will mildly exalt depressed functions or check excessive ones, to bring them, in brief, and hold them for a time up to the healthy standard until sufficiently recovered to act for themselves, the work of curing chronic maladies will no longer be thrown into the hands of traveling empirics.

The differential I have to suggest in the treatment of acute diseases is that also of over-medication, or too large doses, and not frequently enough repeated. The dosometric system has much in it worthy of attention, and so far as my observation extends, it is decidedly favorable to it, having long ago written upon the subject of

smaller doses and more frequently repeated ones.

In reference to chronic diseases, however, I can confidently aver that a reformation in practice is urgently called for. The abandonment of active remedies, with the calming effects of opiates or of spirituous drinks, and a due attention paid to the laws of health, will work cures where all before seemed hopeless and delusive. The treatment needs to be as chronic in some instances as to extend to a month or more, or at least until all signs of the disorder have disappeared. Of course there are a few diseases like confirmed tuberculosis, cancer and paralysis, that are not radically amenable to any remedies, but if due attention is given to the conditions of health, not fitfully but habitually, then attacks can with few exceptions be avoided. I firmly believe that by keeping all the organs of the body in a healthy state we have the surest of all guarantees that the attacks of microbes can be reduced to a very small degree. Like some others of the class protozoa they can only abide or thrive and multiply amid fouled, unhealthy or diseased tissues and secretions.

In conclusion I can not help remarking my belief that microbes are nearly always a condition and not a cause.

Infant Feeding.

An infant should double its weight in six months, and treble it in a year, if its nutrition is in every way satisfactory. The weighing and measuring should be conducted monthly, and the practical point is this: If a child does not increase at the rate of one pound a month during the first year of life, and twelve ounces a month during the second year, its nutrition is not satisfactory. If a child does not grow nearly three-quarters of an inch every month during the first year of life, and half an inch a month during the second year of life, it is not satisfactory. The latter is, of course, not of the same importance as the former. A nurse should cease nursing if the result does not come near to this proportion with regard to increase of weight. Clearly, premature children would not be so large, though they should increase at the same ratio.—Percy Boulton in *Brit. Med. Jour.*

COMMUNICATIONS.

CLINICAL NOTES ON THE THERAPEUTICAL APPLICATION OF STATIC ELECTRICITY.

G. FRANK LYDSTON, M.D.* CHICAGO.

It has seemed to me that the knowledge of the usefulness of static electricity in medicine has been too closely restricted to the more advanced neurologists; indeed, I do not think that it is so universal even among them as its value justifies. A short clinical paper may therefore be suggestive to the general practitioner, in whose field of work the static current would seem to be of fully as great usefulness as in neurological practice. My attention was first called to the practical application of static electricity by the late Dr. Knight, for many years superintendent of the New York Hospital for Ruptured and Crippled. While sojourning in New York City, I had the opportunity of seeing a number of cases in which Dr. Knight and his talented assistant, Dr. Gibney—the present superintendent—had used the static current for the treatment of chronic joint affections. Dr. Knight, whose experience was certainly very large, was especially profuse in his praises of the static current. I saw the current applied in quite a number of cases of chronic rheumatic and inflammatory affections of the joints with seemingly excellent results. Pain, swelling and impairment of motion were rapidly improved. Local improvement of nutrition was in some cases apparently very rapid, even in joints that had been for a long time diseased. Since entering private practice, I have on numerous occasions had an opportunity of verifying the observations formerly made in hospital practice. I will acknowledge, however, that the results have by no means been so uniform nor as well marked as in the hospital for the ruptured and crippled, a fact which is very readily explained. The constant supervision of the hospital cases and the regulation of diet, the maintenance of rest and the application of massage and passive motion were of course more readily secured than in private practice. Until recently I was in the habit of prescribing static electricity and having it

applied by others under my direction. It has seemed a much more reliable agent since I have personally applied it in my office practice. I have found the static current especially valuable in neurasthenia of various kinds, more particularly in those forms associated with brain fog and sexual hypochondriasis. The application of the static current to the spine has seemed to have a marked stimulating effect upon the genito-spinal center. It has been my observation that in neurasthenia the static current is especially valuable when applied after the general faradic bath. Some eleven years ago I was myself the subject of profound neurasthenia resulting from over-work and the exhaustion consequent upon a dissection wound. I at that time developed atrophic changes in the muscles of the hands, which were pronounced by Dr. Lyman and the late Dr. Jewell the beginning of progressive muscular atrophy. Associated with this condition was a decided tendency to melancholia and some slight paretic manifestations in the lower extremities. I also experienced frequent attacks of palpitation and cardiac dyspepsia. I began the use of the general faradic bath, but the result was apparently an increase of the condition of depression with which I was suffering. On combining the general faradic bath with the application of the static current to the spine I experienced a most exhilarating and tonic effect. When as a matter of convenience I stopped the general faradic bath, I found that I obtained very nearly the same effects from the static current alone. It was several years before I recovered the use of the muscles of the hands, and even now atrophic changes are apparent, but the neurasthenic symptoms from which I suffered improved rapidly and practically disappeared within two or three months after the beginning of the treatment.

I will take the liberty of briefly presenting a few cases in which static electricity has seemed to me to be of considerable value.

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CASE I. This case was that of a physician, 40 years of age, whose condition in many respects resembled my own as far as neurasthenia was concerned. The gentleman had been advised by several prominent physicians to change climate as he had a slight cough and tuberculosis was feared. Another well known-physician had stated in a very ambiguous way that the fault lay entirely with the gentleman's liver. Between these two opinions the changes had been rung upon a large variety of forms of neurasthenia. I found on investigation that the gentleman had been subjected to a great deal of worry incidental to a change of location and financial embarrassment. This, associated with family troubles, irregularity of eating and insufficient sleep had produced neurasthenia associated with considerable digestive derangement. The tongue was heavily coated, the bowels constipated, the liver somewhat enlarged and tender. The lungs, as far as I could determine, were normal, and the urinary functions perfectly normal. I stopped the nervine tonics with which the patient was inundating himself and put him upon the general faradic bath. He, like myself, complained of the depressing effects of the bath until I added the application of the static current. He called at my office the day after the first application of the static current and said, "Doctor, ever since yesterday I feel as exhilarated as though I had drunk considerable champagne." This effect was maintained, and within six or eight weeks the doctor reported himself as perfectly well, having taken in the meantime no medicine whatever, save a saline in the morning from time to time, as required.

CASE II. A young lady, 16 years of age, was referred to me for lateral curvature of the spine. Electricity in various forms, massage, gymnastics and various appliances had been used with comparatively little effect. There appeared to be a marked general lack of tone associated with local muscular disturbance. The daily application of the static current to the spine and to the muscles of the affected side brought about rapid improvement, and while the deformity has never entirely disappeared, it is scarcely observable, and since a few months after beginning the use of static electricity, has been

readily corrected by very light spinal support.

CASE III. A young lady was referred to me, complaining of palpitations, frequent flushings, severe headache, and a general feeling of weakness. The "hot flushes" as she expressed it, alternated with extreme coldness of the extremities. The pulse was 120 and somewhat irregular. Both Dr. Moyer and myself thought we detected from time to time a slight systolic bruit. The patient also had occasional attacks of gastralgia, and *suppressio mensium*, which lasted for six months. I could find absolutely no organic condition to account for her symptoms. She was to all appearances a buxom and healthy young woman, had plenty of color, and her general appearance was incompatible with some of the symptoms with which she complained. My colleague, Dr. Moyer, who saw the case with me, was equally at a loss to explain the symptoms present. Personally I suspected incipient Grave's disease, and in this Dr. Moyer coincided. The patient was under treatment for about four months without obtaining any relief. I then put her upon static electricity, using the wind current over the entire back and sparks to the spine. The patient was so sensitive at first that the treatment seemed very severe, but she soon became accustomed to the current and tolerated it fairly well. Within a month after beginning the treatment the menses reappeared, and began recurring every two weeks. They soon became quite profuse, which I considered an indication for the cessation of the static treatment. The menses then became regular with normal intervals. They have been since their reestablishment, however, associated with some pain and considerable prostration for a few days. It might be well to state in this connection that careful examination failed to reveal any disease of the uterus or its adnexa. The patient was a *virgo intacta*. Under the static treatment the patient's general symptoms improved but slightly. Her headaches became especially severe, and the idea occurring to me that there might be a refractive error, I referred her to Dr. James A. Lydston for examination, with the result of discovering a considerable degree of astigmatism. This was corrected by a proper glass, and I have rarely seen so happy a creature as my patient has since

been. She appears at the present time perfectly well excepting at the menstrual epoch.

CASE IV.—A young man, 18 years of age, received some ten years ago a severe contusion of the hip with resulting osteoperositis of the femur in the vicinity of the great trochanter. He had at times been quite lame and had suffered considerable pain and tenderness in the affected part. The patient had taken all kinds of treatment, but was averse to any operative procedures. I therefore began experimentally the use of the static current with the result of a marked amelioration of the symptoms. The enlargement of the bone at the site of the disease soon appreciably diminished. There is a question in my mind whether the application of electricity will be sufficiently efficacious to avoid the necessity of an operation. The amelioration has up to date been sufficiently marked to afford considerable encouragement in this class of cases.

CASE V.—A young man, 22 years of age, during the course of an acute gonorrhœa developed gonorrhœal arthritis of the right knee. This resulted in slight ankylosis, which was broken up from time to time, the usual application of passive motion being subsequently made. The joint remained stiff, tender and swollen for some time. Counter-irritation and various forms of internal medication were apparently of no service whatever; but under the daily use of the static current the condition rapidly improved, and within 8 or 10 weeks the patient was practically well. The patient claimed that he himself could see a marked improvement from day to day in the early part of the treatment.

CASE VI.—A gentleman, 45 years of age, consulted me regarding what to him was a very embarrassing predicament. He claimed that for some months his sexual vigor had been gradually deteriorating. Some three months before he consulted me, his wife had gone away upon a visit, and he improved the opportunity to indulge in all sorts of dissipation with the exception, strange to say, of sexual excess, which, however, he confessed he would have indulged in if he had the slightest inclination thereto. On the return of his wife several weeks before he saw me, he found he was absolutely inca-

pable of fulfilling his marital duties, both from sexual indifference on his part and an actual lack of vigor. Under the use of the static current to the spine the patient rapidly improved, and within ten weeks was restored to his normal condition of virility.

CASE VII. A gentleman, 30 years of age, was referred to me by Dr. John Bartlett of Chicago. The patient complained that his sexual vigor had become impaired, and that for two months he had suffered with severe pains in the small of the back, which were greatly aggravated by sexual intercourse and by changes of weather. At times he found that he was unable to follow his vocation, that of a mason. I found that the patient had a narrow and irritable meatus and a stricture of large calibre at a depth of half an inch. The prostatic urethra was also exceedingly tender and irritable. I performed anterior urethrotomy and passed sounds every few days thereafter in the usual manner, but without any resulting improvement. The patient was beginning to be rather discouraged, and I suggested the use of static electricity. The current was applied to the lumbo-sacral region, and in less than a week the pain had almost entirely disappeared. Within three weeks the patient reported himself as feeling perfectly well. He has remained free from pain for nearly three months, with the exception of one occasion, when he had been working very hard during damp weather. A single application of the static current again brought about complete relief. The sexual function has apparently been restored to its normal condition.

I have used the static current in a number of other cases with a greater or less degree of success. In some instances it has seemed to have no effect whatever. I have, however, seen no cases in which it seemed to be injurious, although my experience would lead me to believe that in some delicate and neurotic patients the agent should be used with a certain degree of circumspection.

I will frankly confess that my principal object in presenting this brief paper has been to bring out a thorough discussion of the limitations of static electricity by gentlemen who are much better qualified than myself to express opinions upon the subject.

**DISEASE OF THE EAR AS A COMPLICATION IN EPIDEMIC
INFLUENZA OR GRIPPE.**

LAURENCE TURNBULL, M. D., PH. G.,* PHILADELPHIA, PA.

During the epidemic of influenz or a grippe in 1889-90, and 1891, we treated a large number of cases of ear disease both in the hospital and in private practice, and reported the same in the *Virginia Medical Journal*.

In most of the cases there was earache followed by acute otitis media, with a hemorrhagic inflammation of the membrana tympani, passing into perforations of the membrana tympani, the result of a micro-organism migrated from the naso-pharynx. In some of the cases there were double perforations with more or less reflex irritation of the brain, and some involvement of the mastoid, followed by tissue abscess situated just beneath the cortical layer. There was pain, chill, and more or less fever, followed by perforation of the membrana tympani; at first a mucous and, after a time, a discharge of pus. In almost all the cases there was a feeble circulation, irregular pulse and weak heart.

Instead of yielding promptly to the ordinary treatment by sterilized cleansing with a solution of baborate of soda and glycerine, cocaine solution at night to relieve pain, it had to be followed by carbolic acid with boric acid and aqua pura and careful inflating of the middle ear. Most of the recent cases were protracted for three, four, and even six weeks, and some longer. Then the apophysis of the mastoid became painful, and still more so on pressure. The insufflation of air diminishes the pain for a length of time but leaves the apophysis sensitive to touch, then we resort to the following prescription: Baths for the ear, of alcohol at 90 per cent. containing 20 grammes of po-phryised boric acid, or a super-saturated solution which Lowenberg introduced into use for the past twelve years with success in this class of cases.

In the adults there was a large loss of the membrana tympani of a pyriform shape. The nose, throat and Eustachian tubes were inflamed and irritated, requiring spraying with a solution of aqua hy-

drogentii deoxide 3 per cent. solution with half water, until all secretions were removed, while the pain was relieved by cocaine at night, and then toning the part with liquid albolene and menthol, equal parts, of this using 2 to 5 of the albolene. This treatment had a most happy effect upon the second stage of the rhinitis. Tonics had also to be freely administered. Simple elixir of U. S. P. with phosphate of iron and strychnia, omitting the quinia and substituting salacin. Salacin acts as a mild tonic reduces temperature, excites perspiration and relieves the catarrh and hyperæmia of the naso-pharyngeal mucous membrane. The quinia is apt to increase the tinnitus aurium which was one of the annoying symptoms.

Ever since 1891, there have been more or less sporadic cases as sequelæ of this distressing malady. In a case which we visited very recently in consultation, the daughter of a physician, a girl three years old, following an attack of grippe both ears discharged pus and both membranes were perforated. She was pale and feeble and had been in her room for three weeks. The posterior nares were so much affected that a young physician thought from the symptoms she had adenoids and proposed their removal. We found no indications of such growth, but irritation of the mucous membrane extending from the pharynx into the Eustachian tubes. This unfortunately had not been attended to and the tubes had not been kept free. This can so easily be done and should never be neglected, for by simply passing a short rubber tube of four or five inches, armed with a nozzle, into the nose and while the child cries, blow with the mouth piece, this will open the tube, which should be kept open every day after cleansing the nostrils and ears.

The child had no appetite for food and was weak. We therefore ordered essence of beef and eggs soft boiled, as this latter is the only perfect food we have. The essence of beef acts as an admirable stimulant, using a quarter of a teaspoonful of "Armour's Extract" to a cup of warm

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water, adding a little salt to this makes a nice drink and few children will refuse it. We also ordered the wash before referred to, and the tonic. It is wonderful what large doses of strychnia can be given in these feeble conditions following gripe, so as to tone the heart and improve the appetite and digestion. This child was reported well after two weeks treatment.

CONCLUSIONS.

First. There is a peculiar inflammation of the ear termed influenzal otitis.

Second. It almost always commences with hemorrhagic, dark blue or black bullae seen in the lower posterior segment of the membrana tympani.

Third. After a time a perforation of the membrana tympani takes place with a discharge of bloody muco-serous fluid.

Fourth. The pain, which is severe before the perforation, is not entirely relieved by it and continues assuming more of a neuralgic character. There are subjective noises (tinnitus aurium) such as pounding, hammering and roaring, and if not properly treated by inflation or by Politzer's douche or the catheter, remain after all the inflammation has ceased.

Fifth. Fatal results may follow from meningitis, abscess of the brain, and more frequently sinus phlebitis. Such cases we are called upon to diagnose, being sent to our clinic as abscess of the brain.

CHRONIC MIDDLE EAR INFLAMMATION FOLLOWING INFLUENZA.

There is a class of cases in which the only indication of the effect on the ear is the intense otalgia; no perforation nor discharge. After three weeks or a month the patients present themselves with sunken membrana tympani, and a profound deafness. These cases are promptly improved by the use of the catheter and vapor of chloroform if it is in one ear; or if both are affected the use of Politzer's air bag charged with chloroform or ether, or equal parts of ether and tincture of iodine, a teaspoonful in a pint of hot water, to use in an inhaler; and a liniment of tincture capsici with iodine, to be applied to the mastoid process.

Several cases presented themselves last March, and this treatment with tonics

have improved the hearing after each application, and when followed up restored it to its normal condition.

Common Mistakes of Doctors.

To promise a patient that you will cure him.

To promise that you can render more efficient service than your fellow-practitioner.

To promise that your pills are not bitter or the knife will not hurt.

To promise that the chill or fever will not rise so high to-morrow.

To allow your patient to dictate methods of treatment or remedies.

To allow yourself to be agitated by the criticisms or praises of the patient's friends.

To allow yourself to buoy up the patient when the case is hopeless.

To allow yourself to make a display of your instruments.

To allow yourself to experiment or exhibit your skill uncalled for.

To allow yourself by look or action in a consultation to show that you are displeased, and that if you had been called first matters would have been different.

To allow yourself to indulge in intoxicating beverages.

To allow yourself to rely wholly upon the subjective symptoms for your diagnosis.—*Ohio Medical Journal.*

THE PLAGUE IN CHINA.—A terrible epidemic of the plague is now raging in China for the first time in eleven years. The disease is reported by medical observers to be very similar, if not identical with, the Great Plague of London in 1665; The disease appeared first in Canton the 1st of April, and spread with frightful rapidity among the poorer classes until the deaths had numbered many thousands. Some statements put the mortality at 60,000. About the 8th of June the disease appeared in Hong Kong, where it is now epidemic. At first only the natives were attacked, the mortality being about ninety per cent, but finally the European inhabitants have become victims to the disease, and several deaths have been reported. The daily death-rate in Hong Kong is nearly one hundred. In Canton the spread of the disease continues, but the morality is lessening.—*Boston Med. and Surgical Journal.*

LACERATION OF THE PERINEUM AND RECTO-VAGINAL FISTULA.*

E. E. MONTGOMERY, M. D.,^{*} PHILADELPHIA, PA.

GENTLEMEN:—I bring a patient before you, who is 25 years of age and gives a good family history; her childhood was healthy and puberty occurred at 13; menstruation normal in time, lasted from five to eight days, was always very painful on the second day. She was married at 24, and had one child in July, '93. Labor was of long duration and completed with instruments. She has suffered since considerably from ventral hernia, due to separation of the recti muscles, permitting a protrusion as large as two fists above the umbilicus. She complains of pelvic weight and of dull pain in the pelvis and down the limbs, and has to take frequent rest. Her bowels are constipated, requiring the use of purgatives. During the evacuation of the bowels a small quantity of fecal matter passes into the vagina. The urine is negative.

Examining this patient, we find evidence of laceration of the perineum, the repair of which has been attempted but was incomplete, as an opening remains communicating with the rectum. This communication is above the sphincter, so that the discharge occurs into the vagina. This is naturally a source of great discomfort to the patient, although the opening is very small. We propose to operate to-day for the purpose, first of closing the opening, and second, to repair the perineum, and having dissected up the flap through the point at which the fistula opens, we will close the opening with buried sutures, then introduce sutures to build up the perineum. In this way we feel sure both conditions will be relieved.

To add to the complications we find this patient has a retroverted uterus, which is very painful to the touch and is bound down by adhesions. If we are unable to overcome this while the patient is under the anæsthetic, we will possibly follow the perineal operation by opening the abdomen, tearing up adhesions,

fix the uterus forward, and thus correct the displacement, although it will require a somewhat complicated operation, or rather a series of operations, to do so. It is much better, however, to do the entire amount of operating necessary to correct the condition at the one sitting, rather than to have her look forward to a second siege. With many patients it is a great tax upon time and strength where the means of the patient are limited, to feel that it is necessary to undergo two operations. Neither operation is so critical but what the patient will be able to endure all at the same time.

As a preliminary to all plastic operations we have the vagina thoroughly cleaned, the bowels evacuated in order to remove any scybalous masses that might cause interference with union. The vagina will be cleaned by scrubbing with a solution of creolin and soap in order to remove any material that might possibly infect the wound. The superfluous material will be washed away with sterilized water.

After having placed the patient under an anæsthetic, careful examination is made to ascertain whether it would be necessary to resort to abdominal operation, but by manipulation it is discovered that the uterus can be loosened and a section will be unnecessary. No enlargement of either ovaries or tubes was discovered so that all that was left to do was the plastic operation upon the perineum. Now as you were informed earlier, this fistulous opening projects from just above the sphincter and into the vagina. The perineum, as reconstructed, is defective, so that instead of denuding the surface for a new perineum, we will proceed to split the structure that remains, dissecting the flap upward and carrying it well above the fistulous opening. As the flap is lifted up the incision presents a somewhat crescent shape appearance. Lifting this up, sponging out the parts carefully, I then introduce a suture of kangaroo tendon on either side of the small opening; tying these the opening is secured closely. Sutures are then introduced from side to side, bringing the de-

*Clinical Lecture Delivered at the Jefferson Hospital, March 20, 1894.

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nuded surfaces in apposition, pushing forward the flap to form the posterior wall of the vagina. As the parts are brought in apposition, taking care to sponge out the cavity and remove all blood clots, you see the perineum is again built up, making a good support to the pelvic floor.

The subject of laceration of the perineum is of very great practical interest for the reason that it probably occurs more frequently than any other lesion of the genital tract. It is a lesion that occurs in spite of every precaution that can be exercised, in about 15 per cent. of patients who come to labor for the first time. The conditions which cause laceration of the perineum, are faulty development of the individual; thus, the curve of the sacrum is very marked, or on the contrary, may be slight. In either condition the danger of rupture of the perineum will be increased. The perineum is long, the vulva small, perineum rigid, or the patient may have a large amount of adipose tissue, all of which causes increase the danger of laceration. These are conditions in which the individual is at fault. Then we may have a disproportionate size of the head of the fetus, or it may occupy an abnormal position which increases the amount of tension upon the perineum; occipito-posterior positions or where the head fails to rotate, are causes which increase the danger of the lesion. Then the fetus may have a large head from hydrocephalus. Premature efforts made at delivery of the patient, high application of the forceps, attempts at version, may result in laceration.

The treatment of such a lesion will necessarily depend upon the condition of the individual. Your professor of obstetrics will tell you that in every case in which it is possible, the perineum should be subjected to an immediate repair in order to avoid the suffering to the patient from a defective pelvic floor and the inconvenience of a secondary operation. It should not be forgotten, however, that there are some cases in which an immediate operation would be unjustifiable or unpromising. In those cases in which the woman has been subjected to long duration of labor, where it has been necessary to resort to manual or instrumental interference, the tissues have been very much bruised and lacerated; in such cases

the early union would endanger the patient from the defective drainage and the probability of locking up material which would result from sloughing tissues. Even in these cases, however, where laceration has extended into the recto-vaginal septum, sutures may be introduced in such a way as to restore the septum and give control of the sphincter so that a subsequent secondary operation will be much less difficult, and the patient will not experience the great inconvenience until the parts are in such a condition as to permit of their complete repair. The cases in which laceration of the perineum is complete and has extended into the recto-vaginal septum are those which present the greatest difficulty in securing the proper apposition and restoration of the function of the sphincter. Not unfrequently do we see cases in which the perineum seem to be normal in length, but the patient complains of want of control of the sphincter muscle so that she is unable subsequently to avoid the discomfort of the escape of either flatus or liquid feces. In every operation of complete laceration of the sphincter, the first object of repair should be the restoration of the function of the sphincter as that which gives the patient the greatest inconvenience, and the second the restoration of the perineum.

When we come to the consideration of the treatment of laceration of the perineum the method by which the laceration should be repaired must be dependent upon the particular lesion. You hear of the flap operation, the various methods of denudation and the marked advantages of this and that procedure, but I wish to impress upon you that there is no single operation that is applicable to every individual. The operator should have sufficient ingenuity to fit the procedure to the individual case, and not the case to the operation. You should endeavor to study the necessity and conditions in the case before you, and do such an operation as will insure the most thorough repair and place the patient in the condition nearest that which she had prior to its occurrence. I have repeatedly performed before you various operative procedures, so I will not enter into their further discussion at this time.

I propose to speak of the conditions in this individual besides the laceration of the

perineum, and that is, particularly, the presence of the recto-vaginal fistula. Fistulae are not infrequent in women as a result of lesions that occur during labor. Possibly laceration may take place through the vaginal septum and in the union of the parts a fissure will remain. Possibly a portion of the septum may be subjected to long continued pressure, which has occasioned a loss of its vitality and it has subsequently sloughed, resulting in a fistula. The discomfort of the patient will depend largely upon the size of the fistulous opening. Thus, where large, fecal matter will continually pass through, being a source of great mortification to the patient and her family. In every recto-vaginal fistula, however, it is important that careful examination should be made of the rectum, for not unfrequently such fistulae exist as the result of malignant disease in the bowel. A stricture is formed, ulceration takes place above it and gradually opens into the vagina, in some cases the entire contents of the bowel passing through this canal. In a case which came under my observation recently, a woman was sent to me suffering from a large ovarian tumor, such a case as I would without question have advised to submit to an operation for the removal of the growth; but in making careful examination of the case, introducing the finger into the vagina, I found evidence of the presence of fecal matter, and a large opening existed through the recto-vaginal septum. Introducing the finger into the rectum, it was evident that the gut for some considerable extent was the seat of malignant disease to such a degree that it was utterly impossible to hope by an operative procedure to remove it. Under such circumstances, there was nothing for me to do but leave the patient to bear her burden. Sometimes these fistulae may result from the presence of an abscess in the wall of the rectum, from a suppurating hemorrhoid, or traumatism, so that a small fistulous opening is present.

There are various methods by which such openings may be treated; simply denuding the vaginal surfaces would not be sufficient. If we have a small opening, the better procedure would be to dissect up a flap, as we have done in this case, close the opening by buried sutures and then stitch over it the flap. A vertical incision may be made

directly through the opening, dissecting a flap upon either side, introducing the buried sutures, stitching the vaginal flaps over it. This method of treating the case accomplishes giving as little pressure upon the parts as is possible. The buried suture may consist of kangaroo tendon, small catgut or fine silk, using preferably that which is used for operations upon the eye. If this is carefully disinfected by heat, and care is exercised in its introduction, it gives no inconvenience. In some cases where the introduction of the sutures leaves a gaping opening in the rectum, it would be better to introduce sutures in the rectal mucous membrane in such a way as to hold the surfaces in contact to prevent the soiling of the wound until the union has taken place. As we have closed the fistulous opening in the patient upon whom we have operated this morning, and restored the perineum, I do not have the slightest fear of any redevelopment.

I feel that in this patient we have been also fortunate in being able to avoid the necessity of doing an abdominal operation; in other words, to bring about the correction of the displacement without the necessity of subjecting her to abdominal section. The correction of such displacements in all such conditions, is exceedingly important, as where the uterus is retroverted, presses upon the rectum, it gives rise to a congestion of the lower vessels of this organ, particularly where the stump is heavy, producing probability of delay in union, and even not only failure to unite, but sometimes, through the ulcerative process, increases the size of the opening, so that I make it a rule never to perform an operation upon the rectum until I make sure that the rectal disease is not a result of some malposition or enlargement of the uterus.

Incontinence of Urine.

R:	Tincturae belladonae.....	ss
	Tincturae cubebae.....	ss ssij
	Tincturae nucis vomicae.....	
	Tincturae rhois aromaticae, of each.....	ssj
	Tincturae cascariellae.....	ssij

12 drops at bed-time for a child from seven to ten years.

A mixture of chloroform (ten parts) ether (fifteen parts) and menthol (one part,) used as a spray, is recommended as an excellent and prompt means for obtaining local anaesthesia, lasting for about five minutes.—*Boston Med. and Surg. Jour.*

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SATURDAY, JULY 28, 1894.

EDITORIAL.

ERRORS OF MEDICAL WRITERS.

Some time ago we read in a religious weekly, which is ably conducted, the assertion that Fielding in one of his novels had spoken of an insane asylum, one of the inmates of which was trying to extract sunbeams from cucumbers. Two great errors were committed by the writer, errors which our readers so readily recognize it is unnecessary to point them out. The writer was a very scholarly man, his life chiefly spent among books, and his making such mistakes would therefore seem highly improbable.

Corresponding errors are not uncommon on the part of medical writers. Errors as to dates, as to persons, and as to priority; one form of the latter is claiming as original that which was done by another years before. Now in regard to the last topic, undoubtedly truths and methods of practice may be re-discovered, for as one of the great philosophic writers has said, "Novelty is only oblivion." Yet in other instances the author has read, or

been told that another has said, or devised this or that; the days go by, and the information has faded from his consciousness, but the fact without its source revives in such a way that it seems an original conception, and so he publishes it. We purposely omit in our consideration those depraved creatures who deliberately steal another's invention, proclaiming it as their own, and who deserve nothing but general professional contempt; they are as bad as the doctors who steal patients, or slander fellow members of the profession, and like them should be sent to Coventry, since there is no penitentiary provided for such culprits.

The errors we shall consider may not involve any great culpability, but still they can hardly be called venial, for a man who assumes the responsibility of teaching the profession ought not to be careless as to dates or persons, and ought to be accurate in his statements when, by careful research, accuracy is possible.

We shall point out some of these errors, chiefly for a reason similar to that given in former times by an English judge, when sentencing a horse-thief, "You are hung, not for stealing a horse, but in order that horses may not be stolen." In an excellent and well-known work upon Obstetrics we read: "Wallace praises vinegar as a certain and safe remedy for *post-partum* hemorrhage." Reference is made to the third volume of the Transactions of the American Gynecological Society. The reader in turning to this volume, will find that the late Dr. Wallace did not "praise vinegar," but this commendation was given in an admirable practical paper upon *post-partum* hemorrhage by Dr. Penrose. In the same work Leyman is referred to in connection with an extraordinary knot of the umbilical cord. Now in some French works the name is given thus, but if the original paper by Read, (*American Journal of the Medical Sciences*, 1861,) be consulted it will be found that the case was reported by the late Dr. George H. Lyman of Boston. We would not refer to these instances if in a review of a preceding edition the errors had not been pointed out; probably the author did not see the review, or seeing it, did not think the errors important enough to correct.

Within the last few years there have been papers in medical journals advocating the application of moist sponge and compression in the treatment of mammary abscess. Before these articles appeared the second edition of Gross's *Surgery* was published, 1862, and in it the following passage, relating to mammary abscess, is found: "Within the last few years, a more scientific mode of management has been extensively pursued in this country, in consequence of the recommendation of Dr. Foster. It consists simply in the application of compressed sponge," etc. The compressed sponge was applied after the abscess was opened and the breast covered with cotton batting; then a bandage was

neatly adjusted, and from time to time water put upon the bandage, and of course the sponge thus became swelled, making equal and gentle pressure upon the organ, securing the apposition of the walls of the suppurating cavities, and thus union more promptly than by other methods of treatment. Many American practitioners were employing this method of sponge-treatment more than thirty years ago: but some recent writers seem not to have learned it.

In 1859, Dr. Paul De Lacy Baker, of Eufaula, Alabama, first used veratrum viride in the treatment of puerperal eclampsia as may be seen by referring to the *Southern Medical and Surgical Journal*, September, 1859. But in a recent paper in the Transactions of the American Gynecological Society, it is stated that the first employment of the remedy for this purpose was by a Brooklyn doctor, giving a date some years after Dr. Baker's use of the agent.

A few months ago a practitioner of recognized ability, proposed the use of a French toy balloon for exposure of the fistulous margins in operating for vesico-vaginal fistula. But Foucher (*Gazette des Hopitaux*, 1862,) had anticipated him more than thirty years. The method of Foucher is referred to in the important volume of Deroubaix, *Traite des Fistules uro-genitales de la femme*, 1870. The only difference is that the Frenchman filled the rubber reservoir with air, while the American employs warm sterilized water or Thiersch's solution.

We might continue our list for some time, but it seems unnecessary. If this exposure shall have any good effect in lessening carelessness on the part of medical authors, and encouraging literary research in professional subjects upon their part, its object will be accomplished; its only purpose is, referring to the illustration given to prevent horses from being stolen.

ABSTRACTS.**POSTERIOR URETHRITIS.**

Dr. F. Tilden Brown, in a paper with this title, says: Acute posterior urethritis rather a complication than a sequence of anterior urethritis. Some think that the anti-infective agent of gonorrhœa is conveyed from the anterior to the posterior urethra, and other portions by means of the lymph channels. Most observers, however, are inclined to believe that the disease traverses to the posterior urethra by continuity. At any rate, between the 16th and 26th day, an extension generally takes place to the posterior urethra. When the bulbous urethra is filled with pus there may be pressure upon it, by the clothes or otherwise, which favors its continuance. Locomotive engineers, tailors, oarsmen and bicyclists seem particularly prone to this complication. The paucity of glands, lacunæ and follicles in the posterior urethra, as compared with the anterior urethra, seems to offer the best explanation of its frequently escaping infection. He had seen several cases in which the fluid has passed into the bladder during irrigation of the urethra with a Kiefer nozzle. Spontaneous extension of an anterior urethritis to the posterior urethra may be expected in a debilitated person. The subjective symptoms may be at first wanting, and hence the condition may for a time be overlooked, and not be discovered until after the patient again indulges in sexual intercourse, when the sudden reappearance of the discharge may lead him to think that he has suffered a new infection. There is, however, more commonly a sudden development of dysuria and disturbance of the sexual apparatus. Tenesmus is the all-important symptom in posterior urethritis, and there will be urgent demand to urinate, which, if not immediately attended to, will lead to a dribbling of the urine. Spermatozoa may be present with undue frequency in the urine, and lead to a suspicion of the existence of a posterior urethritis. In acute posterior urethritis, instrumental examination is contraindicated. By rectal examination by the finger, it will be found that pressure upon the prostate gland will cause pain and tenesmus. When the affec-

tion is severe there may be marked constitutional symptoms. Unless the disease be carefully and systematically treated, there will be frequent relapses. In the treatment the tenesmus must first be relieved by the use of suppositories or deep injections of cocaine or morphine. The urine should be rendered nearly neutral, using the benzoate of ammonia when the urine is alkaline, or the bitartrate of potash when the urine is acid. Sandal-wood or salol may be administered internally. After the subsidence of the acute symptoms, deep urethral injections of very weak solutions of nitrate of silver may be employed. In chronic posterior urethritis the amount of disturbance is quite variable. In what proportion of cases the gonococci cease to exist is not known, but all such cases should be looked upon as suspicious. To determine whether or not a case is still capable of carrying infection, it may be necessary to produce an exacerbation of the disease by the introduction of an irritating solution, for it is well known that gonococci are much more numerous during such an exacerbation. The subjective symptoms are similar to those of the acute form, except that tenesmus is usually absent. The existence of the "comma" thread in the second urine glass is strongly suggestive of chronic disease of the posterior urethra if disease of the anterior urethra can be excluded. If disease of the anterior urethra cannot be excluded, this portion of the canal should be thoroughly irrigated, then the first passage of urine would indicate the condition of the posterior urethra. Deep pressure over the membranous urethra and perineum is more likely to show tenderness than digital examination of the rectum. Here the urethoscope is exceedingly valuable. At the first examination the lesion is exposed, and a 3-per-cent. solution of nitrate of silver applied by means of a specially devised syringe with a cotton tip. This treatment should usually be repeated after two or three days. When the submucoous layers are infiltrated, absorption will be promoted and better results obtained by the use of iodine.—*Jour. Cut. and Genito-uri. Dis.*

THE INTERNATIONAL SANITARY CONFERENCE OF PARIS.

The International Sanitary Conference of Paris, which has just closed a two month's session, marks another advance in the progress of state medicine. This was the seventh similar conference, but the results of its work are to prove far more important than any of its predecessors. While other conferences have considered questions more immediately relating to cholera in Western Asia and Eastern Europe, this Conference grappled with the more difficult subject of preventing the transportation of the cholera infection from India by the pilgrims to Mecca.

This problem is beset with difficulties from whatever side it is approached. On the one hand are the religious superstitions of the Musselmans that render them intolerant of any control; on the other are the jealousies of local governments, which make them resent any interference with their subjects by other powers, and, finally, there are innumerable complications arising from European territorial and commercial interests. It appears, however, that the Conference was able to solve all of these perplexing difficulties, and formulate an international series of regulations upon which the states represented will finally be able to unite.

Great credit is due the French Government for its persistent effort to secure international co-operation in the prevention of the spread of cholera. It called the first Conference as early as 1851, for the purpose of securing a uniform system of quarantine, but the results were not attained. In 1859 it attempted to secure a Conference, but the draft of the convention was not acceded to. In 1866 it succeeded in having a Conference of all the States of Europe, Egypt and Persia, at Constantinople, where many of the questions relating to an international agreement on methods of preventing cholera were discussed. But the time had not arrived for the adoption of the regulations proposed, and the Conference failed of immediate results. But it is apparent that there was a much nearer approach to an agreement than heretofore. Three Conferences have since been held, viz., at Rome, Venice, and Dresden, all of which resulted in agreements as to the methods of dealing with cholera in Europe. Finally, the Government of France called the present Conference, and its programme

brought prominently forward the question of an international agreement on regulations governing the pilgrimages to Mecca.

The results arrived at were the adoption of regulations which place the pilgrim under strict sanitary care from his departure to his return home. He must first secure a sanitary passport from the local authority, giving full details as to his person and locality; at the port of departure he must be detained for cleansing and disinfection; he can embark only on pilgrim ships; these ships must have a qualified physician, ample space, pure water, good food, a disinfecting apparatus hospital accommodations, etc.; island stations are provided, having every necessary appliance for cleansing and disinfection, where the pilgrims debark and undergo cleansing, as also the ship. At Mecca the pilgrim is under rigid surveillance, and on his return receives another passport stating his condition. The code of regulations is very minute, and if they are enforced in good faith would seem to render it impossible for cholera again to spread from India along the routes of the pilgrimages as heretofore.

We learn that the delegates from the United States endeavored to have the delegates from the Conference add to its programme the closely allied subject of the prevention of the spread of cholera by emigrants from Europe to the United States. The suggestion was favorably received by the Conference, but as the delegations were selected for the express purpose of considering the pilgrimages of the Musselmans, it was decided to postpone the emigrant question to a future Conference. It is greatly to be regretted that this Conference could not have included the emigrant with the pilgrim, for the larger number of the regulations made for the latter would apply to the former. Every emigrant from Europe to the United States ought to be required to obtain a sanitary passport from the local authority, setting forth the health of the locality and other details as to the cleanliness of his personal effects, freedom from all forms of infection, etc. Without this passport he should not be allowed to embark for this country. At the port of departure he and his baggage should undergo the same cleaning and disinfection.

SOCIETY REPORTS.

LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

March 23, 1894.

[STENOGRAPHICALLY REPORTED BY C. C. MAPES.]

SYMPATHETIC OPHTHALMIA.

DR. WM. CHEATHAM: This little boy seven years of age, a year ago last November was struck in the right eye by a piece of steel, splitting the cornea, resulting in a cicatrix extending all the way across the cornea, and adhesion of the iris the full length of the wound above and below, with complete closure of the pupil. One year afterward the left eye began to be disturbed. About Christmas there was considerable inflammation in the left eye; this progressed until there was only perception of light, with occlusion of the pupil, with almost total posterior synechia; the iris in some places, where it is not entirely attached you will see the aqueous humor in the posterior chamber pushing it forward. This case brings up several points of interest in which I would like to have the help of the oculists present. One question now, is whether the injured eye is not going to be the better of the two? He now has quick perception of light in both eyes; in passing along the street he can tell when he comes to the gas lights, etc., and can avoid running into objects or persons without any trouble. Ten days ago I took out a small section of the iris of the right eye and also did a small iridectomy on the left. As is usual in these cases, the iridectomy wound was entirely closed in the left eye. This is about the only form of iritis in which we cannot make a satisfactory artificial pupil and for this reason I would advise to wait for months or sometimes years before trying surgery in a sympathetic irido-cyclitis—if you make an iridectomy it will almost invariably close. I believe the time for enucleation of the right eye in the case before us has passed, as by the sympathetic involvement of the left eye the right will likely be of the most service; while it is small and partially shrunken I think it would be of considerable service if we could only get a pupil. Another point

in regard to operating on the right eye is whether any lens is present; of course it is uncertain whether the lens is in position. If we could be sure that the lens is intact, then an iridectomy would be the proper procedure; if not an iridotomy would have been the better.

The case brings up another question as to the cause of sympathetic ophthalmia; I do not think professional opinion is at all settled. Whether it travels along the optic nerve, the ciliary nerve, whether it is microbic, or what is the origin of sympathetic ophthalmia. All theories may be correct; one in a given case and another in another. The question comes in here whether it is possible to have sympathetic ophthalmia without an opening in the eye-ball. My own opinion is that we can, because we have it in cases in which there is absolutely no history of trauma. I have seen a case where the ciliary body was involved, where the eye was diseased as a result of syphilis, and sympathetic trouble set up in the other eye, where there had been no opening whatever through the sclera. Of course that decides against the theory of the microbic origin of sympathetic ophthalmia, because unless we have a broken surface the microbe cannot enter. In these cases though it is contended that there is a microscopic tear in the surface through which the microbe enters, and thus we have sympathetic ophthalmia.

Knapp divides these cases into "sympathetic irritation" and "sympathetic inflammation," and states that irritation gets well, but the cases of inflammation do not get well. I cannot agree with this statement, as I have seen a great many cases of inflammation get well.

The most remarkable case that I ever saw, was one in which the man could scarcely tell daylight from darkness. I saw the case with Dr. Vance, and under local anaesthesia we enucleated the bad eye and with treatment the patient se-

cured vision of $\frac{1}{2}$ in the remaining eye. I read a report of a case recently where a man had gotten vision of $\frac{1}{2}$. I saw a case with Dr. Dabney some time ago in which the result was vision of $\frac{1}{2}$. These were all undoubted cases of sympathetic inflammation.

There is another point of interest in the case of the little boy before us. Of course we all recognize that enucleation of the injured eye in the beginning would have been the proper thing, still there are some dangers in enucleation; the danger of anaesthesia, some danger of sepsis, hemorrhage, meningitis and death. I have seen two cases of very serious hemorrhage the result of enucleation of the eye. Dr. Cartledge will remember having seen with me two cases of acute insanity following enucleation of the eye. Sometimes erysipelas and panophthalmitis follow as a result of enucleation. Cases of death following enucleation of the eye are not at all common, although we must admit there are some serious dangers connected with the operation. I have seen a series of 500 to 600 cases reported without a single death. Another operator reports 600 cases with only one or two deaths.

I would like for the Fellows to examine the eyes of this little patient and make any suggestions they may be able as to what ought to be done. The case is particularly interesting to me because I have at present six cases of recent trauma with just such injuries as this, in which the question comes up whether enucleation should be done or not. One is in the person of a child eighteen months of age who inflicted an injury to its eyes with a pair of scissors. Another a child brought to be from Indiana, injured her eye while at school with a pencil. As I have said I have under observation now six cases of recent trauma in which the question of enucleation of the eye comes up. I know some of you may say wait for a while and see if any sympathetic trouble sets up; if this is done it may be neglected until it is too late for enucleation. I believe however that this would be wise if the patients could be kept constantly under observation, because we have a period of sympathetic irritation just preceding inflammation. In the case I have mentioned of the child eighteen months old, there is no sight in the affected eye, it is soft and has

shrunken fully one-third, the eye being about two-thirds its normal size.

DISCUSSION.

DR. S. G. DABNEY: I agree with what Dr. Cheatham has said, that the time for operative measures in the case presented has passed so far as the eye originally injured is concerned. I certainly favor leaving the injured eye in this case, as I believe the chances of vision are more favorable than in the sympathetic eye, in view of the fact that the iridectomy upon it has remained open better than that upon the sympathetically inflamed eye. Outside the case presented by Dr. Cheatham, the subject is extremely interesting and one of great importance. In enucleation for panophthalmitis Noyes after reviewing the whole subject thoroughly, gives the proportion of deaths, one in 4000. Different writers differ widely as regards the advisability of enucleation during acute panophthalmitis. Fuchs in his recent book advises against it. Most American writers as far as I am aware rather favor it. Roosa in his edition of Shmidt-Rimpler's work, states that results from operative measures in acute panophthalmitis are in most instances very satisfactory. The case Dr. Cheatham refers to which he was kind enough to see with me possessed a great many features of interest.

It was the only case of suppuration I have had in operation for cataract. The patient was a lady sixty years of age. Her general health was bad. I had an analysis made of the urine before operating, always feeling somewhat anxious about the case and had some hesitancy about operating, but the examination revealed nothing abnormal. The operation itself seemed to be according to rule as far as that was concerned. The next day she could count fingers easily and there was no pain or other disturbance. Forty-eight hours afterward the suppuration began. Possibly her own imprudence the night after the operation had something to do with it. She passed water perhaps a dozen times during the night, and insisted upon getting up. Panophthalmitis followed and I rather advised enucleation, I did not however, urge operation because many writers on the subject advise that removal of the eye should not be done during an acute panophthalmitis, because of the danger of meningitis and because the dan-

ger of sympathetic ophthalmia following such inflammation is very slight. The patient was unwilling to have the eye removed and asked to have another opinion. Dr. Cheatham and myself consulted in regard to the case, and agreed considering the very slight danger of further trouble, and considering the patient's own wishes, that we would leave the panophthalmitis eye. The case went on without any unusual result for six weeks. She was suffering very little pain, being built up with tonics, etc., in the meantime. Six weeks later she came to my office, saying that three or four days previously she had begun to have pain in her good eye. An examination showed at once that she had an iridocyclitis or iridochoroiditis. In view of the fact that Dr. Cheatham had seen the case previously I asked that he again be called to see her. Of course the only indication was removal of the stump of the panophthalmitis eye, and we advised that this be done immediately. This was late Saturday evening and the patient had then been suffering with sympathetic inflammation for at least four days, but as she did not understand the gravity of the case I was not called earlier. I removed the eye on Sunday morning twelve hours after seeing her; the inflammation subsided immediately and she now has perfect sight in the other eye being 20-20. That was certainly a case of sympathetic inflammation which we have every reason to believe was cured by removal of the offending eye. In regard to operative measures when sympathetic inflammation has already begun or existing and the patient still retain sight—the rule is not to remove the first injured eye, because as Dr. Cheatham has said, often the ultimate vision in this eye is better than the one subject of sympathetic inflammation.

DR. J. M. RAY: The question of sympathetic ophthalmia and the kind of eye troubles likely to give rise to sympathetic ophthalmia, is an extremely interesting one. We are all agreed that injuries to the eye, especially injuries involving the cornea with adhesions of the iris, or wounds involving the ciliary body, are the conditions which are liable to be followed by or give rise to sympathetic ophthalmia. As to whether sympathetic ophthalmia follows any inflammatory disease of the eye without rupture or perforation of

the eyeball, is a disputed question. The accepted teaching of the present time in reference to the cause of sympathetic ophthalmia, is that it is microbic in origin. Deutschmann has made some very interesting experiments on this subject, and most authorities agree with him, and if his experiments and statements are true it is impossible to have a sympathetic ophthalmia without rupture of the eyeball.

At the meeting of the American Ophthalmological Society last summer, Dr. Knapp reported a case of sympathetic ophthalmia resulting from a wound of the eyeball with a dislocation of the iris under the conjunctiva without any external wound; after reporting this case in discussing the subject he made the statement that it was the first time he had seen sympathetic ophthalmia follow without an injury of the external coats of the eye. It seemed to be the opinion of those present that sympathetic inflammations were not liable to follow unless there was an injury to the eyeball giving rise to perforation.

Dr. Cheatham will remember seeing a case recently which I have under observation for several years. A young lady came to me three years ago with a small circumscribed spot of chroiditis which has gone on from bad to worse. The inflammation extended form the choroid to the ciliary body producing extensive cyclitis; from that it extended to the iris, but the external tunics were still intact. When I first saw her an examination of the other eye showed one or two small spots on the choroid with one considerable side spot extending far out just back of the lens. She began to have some little sensations referable to the outer eye. Things looked steamy at times. She went on this way for probably six months with the sight of the other eye remaining as good as formerly. Meantime she went to Chicago and consulted her brother (an oculist), who saw the case at about the time when the inflammation was worst in the first eye; he sent her back here and asked me to take charge of the case and institute any treatment I thought necessary. I did not look upon the case very favorably and thought she would probably lose the eye. A month or six weeks afterward the patient decided to have the eye removed. I took the eye out. The other eye is just about the same as before.

If the teaching with reference to the cause of sympathetic ophthalmia is correct, it would seem that it is impossible for this condition to occur unless there is a rupture of the eyeball.

In regard to enucleation during panophthalmitis: I have done this in two cases, and the patients seemed to do just as well as they would under other circumstances. I know objections have been raised to the procedure, but I would not hesitate to enucleate the eye during panophthalmitis, if the indications of the case demanded it.

DR. WM. CHEATHAM: Referring to the case which Dr. Ray states I saw with him where the patient had cyclitis and iridochoroiditis: Books state that the thing which produces sympathetic ophthalmia is disease of the ciliary body. That patient certainly has a diseased condition of the ciliary body.

To show that Dr. Ray is mistaken in his remarks in reference to Dr. Knapp's paper and discussion of the same, I will read the following extracts from that paper and discussion, from the transactions of the Society before which the paper was read.

Dr. Knapp says: "That this accident, twenty-five days after the injury, led to the development of typical sympathetic ophthalmia, is not unprecedented if the cases of subconjunctival dislocation of the lens are included in this class of injuries."

"**DR. O. F. WADSWORTH,** Boston: I should like to speak of a case which was a very melancholy one and which occurred some ten or twelve years ago. In this case a spit-ball blown from a toy gun ruptured the sclera in the ciliary region without rupture of the conjunctiva so far as I could make out. The boy was twelve years of age and an only son.

"He came the next day after looking out of the window at the bright sun. There were numerous dots on the membrane of Descemet, the pupil was sluggish and atropine showed posterior synechia. The other eye was enucleated the same afternoon, but he lost sight in the remaining eye within a couple of days. There had apparently been no wound in the conjunctiva and no tenderness on pressure."

"**DR. J. F. NOYES,** Providence, R. I.: wish to relate the history of another case in which I was in doubt what to do. A young man playing base-ball was hit by

the ball on the cheek bone and stunned, but I did not see the case until three weeks afterwards. He then came on account of failure of vision in the eye on the injured side. I also found symptoms of sympathetic trouble in the other eye. I advised enucleation of the first eye, but to this he did not consent. He became totally blind, but neither eye showed any great amount of inflammation. The question arises whether or not the second eye would have been saved if the first had been removed?"

"**DR. HERMAN KNAPP,** New York:—With regard to this case, there was an unbroken conjunctiva. There are in the whole realm of literature only a few of these cases where sympathetic trouble followed where there was an unbroken conjunctiva.

"Sympathetic ophthalmia following a non-penetrating wound is so rare that Boé gives the rule that under no condition need an eye be removed where there is no external injury. That was the case here. I do not think that any one of you have seen sympathetic ophthalmia without an external lesion of the eyeball. It is a process of bacterial origin. Nevertheless there are six cases, and this is perhaps the seventh, where there was no external injury."

"**DR. SAMUEL THEOBALD,** Baltimore.—Dr. Knapp has stated that there are only six cases recorded of sympathetic ophthalmia following injury to the eye without external wound. This, perhaps, may be true, but I think that there have been many cases reported of sympathetic ophthalmia where there has been no wound at all, where there has been inflammation of the ciliary body or deeper structures of the exciting eye without traumatism."

"**DR. J. F. NOYES,** Providence, R. I.—Will Dr. Knapp explain the case that I have just reported where the blow was received on the cheek without injury to the eye, and there was little or no appearance of inflammation in the eye, yet sympathetic trouble followed?"

I have certainly seen cases where there was no injury to the eye and yet sympathetic ophthalmia developed. I still believe that it is possible for this condition to occur without an opening in the eyeball.

DR. S. G. DABNEY: Homor, of Zurich, whose clinical experience in this direction was probably as great as that of any-

body in the world made the statement that sympathetic ophthalmia possibly may occur without an opening in the eyeball, but these cases or instances are very rare. He is in full accord with the theory that these cases are microbic in origin, but states that they may occasionally occur without an opening in the eyeball which can be detected.

ABDOMINAL TUMOR.

DR. A. M. CARTLEDGE: This patient is Mr. H., aged forty years. He has an abdominal growth or displaced viscera, but which I am not yet able to say. The enlargement was first noticed when he was eleven years of age, while being treated during an attack of typhoid fever. Prior to this he received a severe kick about the center of the abdomen (when seven years old) by a mule. When twenty-two years old he suffered with an attack of what was termed congestion of the liver and stomach. He was in bed between three and four months, and was an invalid for a year subsequent to that time; had hemorrhage from both the stomach and bowels on that occasion. After that he occasionally, especially during the summer, suffered from severe bilious attacks, so-called. When thirty-two years old he had the second one of these attacks of congestion of the liver and stomach. Three years ago he had an attack of decided jaundice. Since he was eleven years old he says that he has never been able, on his farm in Virginia, to do any work requiring him to bend over, on account of the soreness which has always been present and the inconvenience caused by assuming a stooping position, and at times he would have this uncomfortable soreness when not attempting to stoop.

The latter part of July I was called to see Mr. H., suffering from intense abdominal pain which was very vague as to its seat. There was some little constipation but the attack had come on with great nausea and vomiting. In examining the abdomen I discovered this enlargement and called his attention to it. There was considerable swelling of the abdomen, tympanites and pain, requiring the administration of morphine for its relief, lasting for about twelve hours. There was some jaundice during this attack, but

no especial tenderness referable to the region of the liver. The greatest point of tenderness was immediately over this enlargement. After resting a few days in bed, he was able to get up and walk about, but in August had a recurrence of the pain. He recovered from this attack very slowly; the jaundice, however, quickly cleared up and after two months sojourn at several watering places, he finally got back to his normal condition. Since that time his health has been fair; he has not lost much in flesh, but still has this tenderness on bending, and the question in the case is simply one of diagnosis as to the nature of the trouble. There is one point which may be of some diagnostic value, and of some assistance. For a number of years he remembers distinctly that this enlargement was possessed of great mobility which has been gradually diminishing until the present time it is more or less fixed in its situation.

DISCUSSION.

DR. J. A. LARRABEE: From the examination I made of this case, I believe it is a detached or wandering spleen caused by the kick of the mule.

DR. J. W. IRWIN: I find that there is no dullness on percussion in the region of spleen, or where the spleen ought to be, but there is dullness on percussion over the left kidney and over the region of the liver. I believe it is a displaced spleen and that it is attached to the mesentery. The hemorrhages that he has had and other troubles may be readily explained by the enlargement of this organ and its dislocation.

DR. J. B. MARVIN: The tumor is certainly behind the gut; it is not the shape of a kidney, and I am inclined to the opinion that it is the spleen.

Dr. J. M. Ray presented a paper on
ADENOID GROWTHS IN THE DOME OF THE NASO-PHARYNGEAL SPACE.

(See page 74)

DISCUSSION.

DR. WM. CHEATHAM: The paper is such a thorough review of the subject up to date that there is very little left to be said. I would also like to add to the paper that diseases of the ear are the most serious complications or dangers from adenoid

growths. Another serious feature is obstructed respiration. The nose is not only intended for olfactory purposes, but also for filtering the air and rendering it more moist. It is said that even the coldest atmosphere passing through the nose, by the time it reaches the larynx is heated to nearly the body temperature. Unless the air is filtered and heated, and unless it is rendered properly moist when it enters the lungs, it is impossible for the proper interchange of gases to take place, as between oxygen and carbonic acid gas. So the question of removal of adenoid growths is not only important from the fact that they are frequently the direct cause of ear troubles, but it is also important in order to secure nasal respiration. Air entering the lung through the mouth, cold, not moistened, not filtered makes it impossible for the proper interchange of gases to go on.

I differ with Dr. Ray in regard to anaesthesia: I do not think I have ever given general anaesthesia to remove growths of this character. I put a gag or cork in the mouth, get some one to hold the patient, then under local anaesthesia removal of the growths can be easily and quickly accomplished. I am afraid of general anaesthesia in these cases since I saw a death in the London Hospital resulting from cocaine, where a child was to be operated upon for adenoid growths.

DR. S. G. DABNEY: Referring to Dr. Cheathem's remarks: I differ with him in regard to the anaesthesia—in young children we ought to give chloroform. I recently operated upon a child who had been operated on in another city for adenoid growths without anaesthesia, and I found quite a large mass remaining which was thoroughly removed with the curette under anaesthesia.

As regards age: I have operated upon children two and three years old, and a number from fifteen to twenty years old. In older children or half grown people, I am in the habit of drawing the palate forward by means of the palate retractor, then passing a curved probe around it and applying cocaine with a pledget of cotton (not the spray) removal may sometimes be accomplished without general anaesthesia.

I believe it to be a fact that many cases such as Dr. Ray describes are overlooked; they may present symptoms not quite so

marked as he mentions; there may be no ear symptoms and not much mouth breathing. I recall one just now; a child was brought to me with a symptom which has not yet been mentioned—vomiting in the morning before, and sometimes during breakfast. He also had obstructed breathing. An examination with the finger showed that there was a mass of adenoids in the roof of the mouth. They were scraped away, and as a result the vomiting, obstructed breathing and all symptoms were relieved. The vomiting was probably caused by the mucus and discharges which had accumulated about the adenoids over night and was loosened by the warm food at breakfast.

Suppuration of the middle ear may often be the result of adenoid tissue in the roof of the mouth. I recently operated upon two such cases in the same family. It is my custom to always make a thorough examination and search for adenoids in every case of suppuration of the middle ear, and in operating for these growths I invariably give chloroform, in small children.

DR. J. A. LARRABEE: From the standpoint of the general practitioner: The statement made by the essayist that a spontaneous cure may be looked for by arrival at adult years, would at first sight seem to lessen the importance of attending to it in childhood. That importance is increased, however, when we consider the consequences that may accrue from such conditions. I am satisfied that in my earlier practice I did not fully appreciate the condition under discussion, and saw many cases of incomplete development of the chest, and the pecten or pigeon breast, and some with curvatures and deformities of the shoulders due to this adenoid condition, which I did not then recognize. When we come to consider the consequences of improper breathing in children from three to fourteen years of age just spoken of by the essayist, we find that while the disease admits of spontaneous cure with growth and development, the consequences produced are not relieved.

I was somewhat surprised to learn that in the Johns-Hopkins Hospital recently some thirty cases were found in the ordinary run of clinics operated upon for adenoids, the usual method being without instruments; the patients being

young and the growths soft, they were removed with the finger nail. I am satisfied that the percentage spoken of by the essayist is in moderation. I believe these cases are more frequent than are recognized. One of the most noticeable symptoms of adenoid growths is the facial expression; if there is anything that can be diagnosed by physiognomy, it is the condition under discussion.

DR. J. B. MARVIN: I think the general practitioner in the city who does not look in the throat nowadays, as well as examining the mouths of all male children has no excuse, as he has certainly heard enough about such conditions. There is one point I think Dr. Ray did not make strong enough. It seems to me that we can make a second division very clearly in these cases, and in the worst class there is not only adenoid growths, but an arched palate, a narrow jawbone encroaching upon the fauces. That seems to me to be a more serious form and more likely to be associated with pigeon or chicken breast than the other.

There is another point in regard to the etiology: Six months ago a child was brought to me for another trouble; a handsome little fellow, and I noticed that he had the habit of jerking his head back. Upon interrogating the mother, she said he was born that way, that he had a "death mark." She having seen a woman die while pregnant. Upon examination the trouble was found to be well-developed adenoid growths, the removal of which corrected the habit.

DR. W. O. ROBERTS: I have had two cases of the nature under discussion, both of which were operated upon by Dr. Ray. The point brought up by Dr. Marvin, the narrow jawbone with arched palate, was very marked in one case, less so in the other. Both patients had trouble in the hearing, and in one of them the hearing was very markedly interfered with; not only was the child subject to frequent attacks of otorrhoea, but it was accompanied with severe pain. Since the operation was performed there has been no trouble in any respect in either case. In both cases there was a very marked improvement in the general health. In the case where there was a purulent discharge, the mother could always tell when it was coming on, by the fact that the ear would become very red; the next day it would have intense

earache, then directly afterward discharge from the ear would be noticed. Chloroform was given in both cases, and I was struck with the ease with which the operation was performed.

DR. J. L. HOWARD: The question that Dr. Roberts has brought up concerning the giving of chloroform in cases of this kind is of great interest to me. I have administered chloroform in six cases for removal of adenoid growths, rather two cases in which there were polypi of the nose and a great deal of hypertrophy in this region, and four cases of adenoid growths, and I have always had trouble in giving the anæsthesia; I came very near having three deaths. I have probably given chloroform three hundred times for different operations, and have experienced no trouble except in the six just mentioned. It may be on account of the obstruction in this region, and I have never administered the anæsthetic for this condition without a great deal of fear.

DR. H. A. COTTELL: About a month ago Dr. Ray and myself went out to operate upon a little boy three years old who had adenoid growths, and who had all the symptoms the essayist has so graphically described. I was particularly struck with the wonderful facility with which the operation was done. The patient was put profoundly under the influence of chloroform, and the adenoid vegetations were scraped out with such speed and facility as to excite my admiration. The operation was practically completed in a few seconds. Hemorrhage was free for a time, but soon subsided. I have seen the patient several times since and I find the result perfect. It seems to me that an operation for the removal of such growths should not be undertaken without an anæsthetic.

DR. J. M. RAY: When I first commenced operating for adenoid growths I probably did about half my operations without an anæsthetic. Where we have a child from nine to ten years old, rather tractable the operation may be done without an anæsthetic by means of the curette.

The specimen which I show you of adenoid growth was removed from a child eleven years old. The trouble dates back to an attack of diphtheria. When the child was five years old he suffered quite a severe attack of nasal diphtheria, and it was thought there was paralysis of the soft palate. It was treated by spraying,

washes, etc., with little or no benefit. The most marked symptom was mouth breathing. I sprayed the throat with cocaine, and with the heart shaped curette which I show you at the second attempt brought the adenoid growth away. In young children two or three years old, I think it is always best to give an anesthetic, as the operation of necessity is somewhat painful. The rush of blood is usually quite free at first but soon subsides, and I have had no after effect whatever from the operation. I have very often removed these growths without the aid of any instrument, simply using my finger nail.

CONTINUED DISCUSSION OF APPENDICITIS.

DR. A. M. CARTLEDGE: At a meeting of this society four weeks ago, I exhibited three appendices illustrating three stages of the pathology of appendicitis. The first was the result of an operation that day, the appendix showing a stenosis commencing about half an inch from the base, with the extremity very much enlarged and distended with liquid feces. I split open the appendix in order to demonstrate the point of narrowing which I thought was of considerable interest. Second a necrosed stump where the appendix had almost entirely disappeared, and third a large perforated appendix. It seems that the appendix which was slit open excited the most discussion, the others having apparently been overlooked.

In view of the various opinions held by members of the society, I think the suggestion made by Dr. Vance that we exhibit before this meeting such appendices as we may have preserved in order to illustrate the pathological conditions, an excellent one. I have accordingly brought twelve specimens for examination, which were all I could get hold of to-day. There were two or three other appendices that I wished particularly to present, but they could not be located in my hasty search among other specimens. One very pretty specimen showing volvulus of the appendix with rupture, was lost in removal.

I have very little to add to what I have already said on the subject; the specimens themselves illustrate the different pathological conditions, and by an examination I believe you will all agree that all of them bear evidences of pathological conditions demanding operation. Perfor-

ation had occurred in nearly every case as will be seen by the specimens, abscesses had formed in most of them and pus was present in all except one; that was the case reported four weeks ago where there was stenosis and distal distension. Many of the patients had been subject to recurrent attacks of undoubted appendicitis, a few were operated upon *in extremis*, others a few hours after the first symptoms developed. One case was treated several weeks for typhoid fever before diagnosis of appendicitis was made. In only one case, I, believe, have I found fecal concretions, and have never encountered a foreign body in the appendix.

DR. TURNER ANDERSON: What has been your percentage of recoveries?

DR. A. M. CARTLEDGE: I have had twenty-two cases of appendicitis up to the present time, with four deaths. This number includes cases of general septic peritonitis the result of appendiceal disease.

DR. T. L. McDERMOTT: Of the twelve cases represented by the specimens before us, how many died?

DR. A. M. CARTLEDGE: Three died out of the twelve.

DR. A. M. VANCE: I have here eighteen appendices, part of which were removed by myself, the balance by Dr. W. C. Dugan. I will not take time to refer to the cases in detail with the exception of one or two. The specimens all bear evidence of a pathological condition demanding operation, and this I think will be apparent by even a casual examination.

At the last meeting of this Society the case of Mr. T. was mentioned by Drs. Anderson and McDermott: I would ask the privilege of reading the report of that case which was made to this Society the day after the operation, and the discussion, showing that pus was present and the perforation in the appendix was seen by all those who witnessed the operation or subsequently examined the specimen.

"**FROM REPORT MEDICO-CHIRURGICAL SOCIETY, MARCH 17TH, 1893. CASE OF APPENDICITIS—OPERATION—DEATH.**

DR. A. M. VANCE: I was called by Dr. McDermott yesterday at three o'clock to see a gentleman; German, forty-nine years of age; very fleshy. He gave the history that in January he had some bowel trouble

which yielded to castor oil and he recovered. In February he had another attack preceded by diarrhoea which was relieved. For a week prior to the time Dr. McDermott was consulted (he was called sixteen hours before he asked me to see the case) the man had been feeling a little "out of sorts" but he thought it was an attack similar to those he had formerly suffered with and kept around attending to his business. At five o'clock Wednesday afternoon he was taken suddenly with great pain in the abdomen, and he got up-stairs with difficulty and went to bed. Dr. Geo. F. Simpson was called in and gave the man a hypodermic of morphine. Dr. McDermott came several hours later and found the man with marked symptoms of shock; he made diagnosis then of probable appendicitis. It was necessary to administer more morphine on account of the severe nature of the pain, salines were given without result, pulse gradually increasing in frequency, temperature 103° F. at one time. I saw the patient at three o'clock yesterday; found temperature $101\frac{1}{2}$ F. pulse 120; abdomen very much distended over the whole area of the peritoneum, tenderness being particularly referred, however, to the McBurney spot. We advised an operation at once.

Drs. Roberts, Kelly, and Anderson afterward saw the case. Last night at seven o'clock the abdomen was opened; an incision was made between the anterior superior spinous process of the ilium and the umbilicus, the man was very fat, fully three inches of adipose tissue being encountered before the true wall was reached. As soon as the peritoneum was punctured pus came out in considerable quantities. With some little difficulty the appendix was found and removed. At the time of the operation the man's pulse was 128. The appendix was quite small and as it was lifted out the distal end was torn and separated, but before it was torn Dr. Roberts and I detected a perforation about the size of a match in the lower portion. The two pieces of appendix have been carefully put together by Dr. Anderson and you can plainly see signs of great localized congestion and make out the perforation. The appendix between this congested end and the cæcum was very small and white. The man had general suppurative peritonitis, rupture having taken place probably at five o'clock day

before yesterday afternoon when the severe symptoms developed.

This instance shows how treacherous these cases are and how important it is to make early diagnosis if possible, so that relief may be obtained by surgical procedure. I have operated twice recently where perforation of the appendix was about to take place and the patient recovered; I have operated twice where perforation had already taken place and both patients died. This man died four hours after operation in shock. He secreted very little urine for several hours prior to operation, and two hours after the operation had been performed I catheterized the bladder and drew off about an ounce of urine; I examined it and found albumen.

DISCUSSION

DR. T. L. McDERMOTT: Dr. Vance mentions two cases of appendicitis in which he operated before perforation took place and in which the operation was successful; also two cases in which perforation had taken place which were not successful. This is the point I want to call attention to. I have had in the past week two or three cases of colic in which there was evidence of as much distress as this patient had. I have frequently had cases of colic in which there were symptoms apparently just as severe as have been found in cases where appendicitis has been made out, and where peritonitis has followed, and it has been a serious question in my mind whether often in cases where appendicitis has been diagnosed, they were not purely cases of colic. While this man had the general symptoms of appendicitis, still owing to his having had several similar attacks and owing to the peculiar condition of the patient, I did not feel that I was justified in saying so positively and advising operation. I do not believe if Dr. Vance had been present when I first saw the patient, he could have said positively that it was appendicitis. The question is whether it is wise to recommend an operation as serious as a laparotomy in cases that may prove to be nothing more than ordinary colic. I am sorry, now, however, owing to the final outcome of the case, that Dr. Vance did not see the patient with me earlier in the attack; still as I had treated this patient in several

similar attacks, I had no reason to believe that relief would not follow ordinary treatment as has been the case on previous occasions. How can we discriminate in these cases between ordinary colic and appendicitis when the symptoms are often identical? The responsibility is very great and certainly it would be a mistake to go into the abdomen in ordinary colic. It is a serious question in my mind whether laparotomy is indicated in these cases. I do say frankly however, that in the two cases upon which Dr. Vance operated I believe the result would have been the same with or without operation. While I am a little chaotic in regard to these cases I believe in another case I shall summon consultation earlier, but in the case reported I do not think operation would have been successful had it been performed earlier. The operation was performed twenty hours after the seizure, four of which were necessarily lost in the attending consultations and subsequent preparations.

DR. TURNER ANDERSON: In the case reported I do not see how it would have been possible to have made a diagnosis that would have justified a laparotomy earlier than was done, especially as the patient was able to be up and attend to his business only a few days prior to his death, and further as he had been subject to frequent attacks of abdominal trouble which yielded promptly to ordinary treatment.

DR. A. M. VANCE: I do not believe it is ever possible to tell just exactly the condition we will encounter when the is opened, but I do think diagnosis can be made with sufficient accuracy to justify operation in nearly every case. Drs. Anderson and McDermott in my opinion, have both laid too much stress upon the dangers of a laparotomy. It is now a well established fact that laparotomy in competent hands and under favorable surroundings is a comparatively safe surgical procedure, and the operation performed last night had it not been for the patient's serious condition, could have done no possible harm. Therefore, I think in the not far distant future all of these cases will be operated upon in the stage that Dr. McDermott first saw this patient. I believe these cases ought to have the benefit of the doubt, and a laparotomy be done for the purpose of diagnosis; I believe

that this will eventually be the practice.

In regard to the differential diagnosis I would not be so presumptuous as to say positively in every case that I could tell exactly the conditions that would be encountered when the abdomen was opened, but I cannot think of anything else but perforative appendicitis or perforation of the bowel owing to some other cause that would produce general peritonitis so quickly in the male except traumatism. Of course the perforation of typhoid fever, is not considered in this case, as there is no such history. Dr. McDermott made the diagnosis of appendicitis when he first saw the patient and I firmly believe if operation had been performed then, the chances would have very favorable for recovery.

(DR. VANCE CONTINUED.)

In the discussion two weeks ago, the question was asked as to how many cases of appendicitis had probably been treated by the different medical men in which the diagnosis was never perfected, the patients died and the deaths ascribed to *peritonitis*. Dr. A. M. Cartledge and myself in the last few days have looked over the Health Officer's statistics and death reports and we have found recorded in the last twenty-three years 168 deaths in males from acute peritonitis, the average age being twenty-eight years. Almost every prominent physician of Louisville has his name affixed to some of these death certificates. We surgeons claim we have the right to believe that the vast majority of these cases of acute peritonitis—so-called idiopathic peritonitis—in the young male and a great proportion in females, are due to appendicitis, and I think this is a great argument in favor of surgical procedure in these cases. The physician does not know, or cannot be absolutely certain, that he has a case of appendicitis until he sees the specimen and the surgeon does not know positively.

Certainly the specimens before us are diseased appendices and they would have caused death in every case had not operation been performed.

DR. A. M. CARTLEDGE: In making the investigation spoken of by Dr. Vance, we excluded all cases of tubercular peritonitis; all cases of peritonitis in the female and all cases where the peritonitis was said to have been the result of injury, and found

as has already been stated 168 cases of acute peritonitis occurring in the male in the city of Louisville within the last twenty-three years, and the death certificate was so endorsed. From past experience it is our belief that a large majority of these cases were appendicitis.

DR. T. L. McDERMOTT: Referring to the quotation Dr. Vance has read from a previous meeting of this society—perhaps it might be well to add a few words in explanation. I had attended the patient, Mr. T., in two previous attacks in which exactly the same symptoms had developed, if anything he was more seriously ill than in this instance, and he had recovered under the ordinary anodyne treatment, opium, salines, etc. I will state also that Dr. Simpson had been called in the last instance previous to my seeing the patient, and had given a hypodermic of morphine, which masked the symptoms to some extent, but at that time I had supposed the trouble was an ordinary attack of colic. I visited him again the next morning and as the temperature was elevated, and he was so profoundly impressed, it then indicated to me that the trouble was more serious in character. Dr. Vance was then called in consultation and the operation was performed shortly afterward. I feel that this patient had the benefit of an operation as early as any physician could have reasonably made a satisfactory diagnosis. While the shock was beyond what we would expect in ordinary colic, still I have seen patients much more profoundly impressed in renal colic and with similar symptoms who recovered without operation. The whole difficulty in these cases lies in the fact, as I stated in a paper read at the last meeting of this society, of our being unable to make a satisfactory diagnosis. I have no doubt if the diagnosis were made at once, if perforation had occurred with healthy structures surrounding it, if the surgeon were called to the case immediately and operate, it would be the proper and only thing to do; but who is able to make such a diagnosis? In the case under discussion I believe the patient would have died in any event; and I further believe that if Dr. Vance had seen the patient earlier a satisfactory diagnosis could not have been arrived at sooner. While I was inclined to the opinion that it was a case of appendicitis, still there

was an element of uncertainty about it, and I felt justified in waiting. Again I had seen this patient get well in several previous attacks in which his suffering was seemingly equally intense, and had also seen numerous other cases having about the same line of symptoms which recovered without operation under the ordinary treatment. How can we discriminate in these cases?

I think the matter is still subjudice, and in writing my paper read before the last meeting of this Society, I did so purely in the spirit of research hoping that it might result in our getting at the bottom of the whole matter and formulating something definite in the way of indications for operation, etc. The only solution of the problem in my estimation is to enter into just such discussion as we have been doing, to tabulate each case in which operation has and has not been done, and the result will be a better understanding of the situation. Possibly in that way we may be able to illuminate the field that is now certainly in darkness in the medical mind.

The Medical Raven.

Once upon a midnight dreary,
The doctor slumbered weak and weary
And all the town could

Hear him snore.

While he lay there sweetly napping.
Suddenly there came a tapping
Like a ramgoat madly rapping
His hard head

Upon the door.

"Get thee up," a voice said loudly,
"Come in haste," it added proudly,
Like a man who owned a million
Or much more.

But the doctor never heeded:
Back to dreamland fast he speeded,
For such men as that he needed
In his practice

Nevermore.

For long months that man had owed him,
Not a cent he'd ever paid him,
And the doctor now will dose him
Nevermore.

—*Atlanta Medical and Surgical Jour.*

Asthma.

The following will be found most useful in this distressing complaint:

R:	Chloralis.....	3ss
	Potassii iodidi, of each.....	13v
	Syrup of oranges.....	13v
	Water.....	
	2 to 5 tablespoonfuls a day.	

THE LIBRARY TABLE.

BOOK REVIEWS.

Clinical Diagnosis. By Albert Abrams, M. D., (Heidelberg), Professor of Pathology, Cooper Medical College, San Francisco, Cal.; Pathologist to the City and County Hospital, San Francisco; Author of "A Synopsis of Morbid Renal Secretions," etc.; President of the San Francisco Medico-Chirurgical Society, (1893-1894); President of the Alumni Association of Cooper Medical College (1888-1889). Third edition, revised and enlarged, illustrated. New York. C. B. Treat, 5 Cooper Union, 1894. Price, \$2.75.

The fact of a third edition of this manual being issued shows its popularity. It has been revised and enlarged and now comprises 273 pages (including a 19-page index) with 28 illustrations. The physical signs associated with disease of the organs in the various cavities of the body are given in minute detail and include many recent additions to the methods of examining these organs. In palpation of the kidney, the author recommends the recumbent posture. In malpositions of this organ it is no doubt better to remain in the erect posture with the abdominal wall relaxed by bearing the weight of the body on arms.

There is a brief account of bacteria with methods of staining.

An appendix contains a chapter on insanity, and many synoptic tables. The work, brief though it be, covers the field pretty thoroughly and the general practitioner will find it very useful in refreshing his memory on many old points, and adding perhaps not a few new ones to his means of diagnosis.

W. E. P.

A Manual of Therapeutics. By A. A. Stevens, A. M., M. D., Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pennsylvania; Demonstrator of Pathology in the Woman's Medical College, Philadelphia; Physician to St. Mary's Hospital and to the South Eastern Dispensary; Pathologist to St. Agnes Hospital. Philadelphia, W. B. Saunders, 925 Walnut Street, 1894. Price, \$2.25.

"This Manual has been prepared," says the author, "especially for students with the hope that it may serve as an outline of modern therapeutics, to be filled in and extended by systematic study of the larger works."

The drugs have been arranged in alphabetical order according to Latin names.

A chapter on "Incompatibility in Prescriptions" has been added by Joseph W. England, Ph. G. The book consisting of 435 pages, includes chapters on "Physiological Action of Drugs," "Drugs," "Remedial Measures Other than Drugs," "Applied Therapeutics," "Incompatibility in Prescriptions," "Table of Doses," and is well indexed both as to drugs and diseases.

The large supply of manuals is some index of the demand for them. This one will be useful not only to the student, but the busy practitioner may often refer to it with profit.

W. E. P.

Differential Diagnosis of Common Diseases of the Eyes. Designed for the use of general physicians by W. F. Conners, M. D., Oil City, Pa. Price, 50 cents.

The author notes that this chart is only intended for general indications, to give the family physician a comparative table of the common diseases of the eye. The intention is to help the family doctor to make a diagnosis without instruments of special knowledge.

W. E. P.

Sexual Neurasthenia (Nervous Exhaustion). Its Hygiene, Causes, Symptoms and Treatment, with a chapter on Diet for the Nervous. Third Edition, with Formulas by Geo. M. Beard, A. M., M. D., etc. Posthumous Manuscript, edited by A. D. Rockwell, A. M., M. D., etc. Published by E. B. Treat, 5 Cooper Union, New York, 1893. (Price, 2.75.)

The late learned Beard says as to neurasthenia:

"There are two points in the male and female that suffer especially when laboring under nervous exhaustion or neurasthenia, i. e., fifteen lines under the prostate gland in the males and thirty lines across the ovary in the female."

These are the prologue of the coming nations; these represent the history of past nations—no medical philosopher except Biliotho ever announced such living gems. Hunter is gone, Beard is gone, and Biliotho is gone. They are gone to the land where an Emperor governs the empire of litters. Nothing shows the man so much as the stamp of individual ideas in every page of his book. It is equal to a liberal education to be allowed to lecture continuously, as did he, in such a school as the University of New York. This book, the third edition, contains 282 pages of strong medical knowledge. The researches began prior to 1868.

Until lately general neurasthenia has been confounded with hysteria, simple hypochondria, some form of insanity, and with the various diseases of the nervous system.

The definition of neurasthenia is not so simple as some would suppose, nor is its causation simple but complex, as is its treatment more medical than surgical, and at times both together, not to direct our attention to one single fault as to emissions solely, to insomnia alone, or to the urinary deposits, but to dig at the root of the diseased tree rather than to lop off each and every effected branch.

Most of the recent works on neurasthenia have been in the German language and they all give especial attention to the digestive and not to the sexual form of the disease. Of the twenty-nine writers in the list only two are in English.

W. F. Mittendorff was of great service in making the urinary analysis. The inferences therefrom are that:

1st. A close attention to the study of the urine showed that spermatozoon is a frequent attendant on all kinds of neurasthenia in the male and indeed in many other debilitating diseases.

2d. That oxalates, phosphates and urates occur in most of these conditions.

3d. That the urine in very nervous persons varies every hour in the day, responding much to the general systemic condition, and especially to the defects of digestion.

4th. That the custom of naming diseases from the character of the urine is fallacious and deceiving.

The author's original essay on neurasthenia was three times declined by medical journals for publication, yet finally became the corner stone of the temple for the treatment of that condition. It was finally published in the *Boston Medical Journal* in April 29th, 1879. The Germans accepted it at once. The original of the work on "American Nervousness" was in effect the chapter on the "Causes of American Neurasthenia," and it was not thought by the publishers to be of any special bearing and scarcely worthy of appearing in print—and indeed it was thought that few would read it, but its repeated endorsement by Mr. Herbert Spencer, in 1882, aroused some interest on the subject.

J. J. C.

Maladies Infectieuses Parasitaires des os, Par Michel Gangolphe, Professeur agréé à la faculté de médecine, chirurgien en chef désigné de l'hôtel-dieu de Lyon. 714 pp. G. Masson, publisher, Paris, 1894.

This work on the infectious and parasitic diseases of bones may be said, to use a thread bare phrase, to fill an actual want or gap in the medical literature for, although in recent years a large number of articles and monographs have been scattered through the literature on the various forms of infectious and parasitic affections of the bones, there has not appeared a full and comprehensive work on these affections. The lesions and characteristic symptoms are continually being studied with the result that they are approaching clearer and better understood types. Under the name infectious and parasitic diseases of the bones he presents those affections of the skeleton generally thought to be dependent upon the action of pathogenic agents, more or less highly organized; microbes or parasites. Tuberculosis, the different varieties of infectious osteo-myelitis, leprosy, hydatid cysts, and actinomycosis are undisputed types. The syphilitic affections, though the exact nature of the pathogenic agent is not yet understood, he has not hesitated to include as well in this classification. The osseous and articular deformations observed during the course of chronic suppurative pleuro-pneumonic processes also are described. The first chapter of the work is wholly devoted to a recapitulation of the generally prevailing ideas on the anatomy, physiology and pathology which are indispensable to an exact knowledge of these pathological processes. The following sections treat successively of tuberculosis, of the different varieties of infectious osteo-myelitis, the osseous and articular deformities noticed in connection with chronic suppurative states of the lungs and pleura, leprosy, the syphilitic alterations in the skeletal system, hydatid cysts and actino-

mycosis. The bibliographic indications of French and foreign works are quite complete. The influence of Ollier, his teacher, is more or less observed throughout the work, especially in the treatment of the different conditions. Indeed, it was in his service that the foundations of the work were laid. The writer deserves thanks for collecting the scattered literature on this subject, and presenting it, with his own observations and deductions, in such a clear and concise form.

F. H. P.

Early Diagnosis of Gastric Carcinoma.

In the *Deut. med. Woch.*, Cohnheim of Boas's Poliklinik contends that it is possible to make a fairly certain diagnosis in the absence of a tumour. The old idea that chronic gastritis is accompanied by lactic and fatty acid formation is disputed, but in cases of carcinoma an intense reaction to Uffelmann's test for lactic acid appears. For such an intense reaction stagnation of the gastric contents and a lasting absence of free hydrochloric acid are necessary. If only one of these conditions is present, as in chronic gastritis or dilatation of the stomach, such a reaction does not appear. The author relates a case in which a simple ulcer was suspected, and in which treatment had no lasting effect. When the stomach contents were at length examined no free hydrochloric acid was present, and Uffelmann's test gave a marked result. The stagnation of the gastric contents here was against chronic gastritis, where the food passes into the intestine within the usual time. Later, besides other symptoms, there was marked wasting, and yet no tumour could be felt. At the necropsy a limited growth was found at the pylorus. The author points out that in this case, in the absence of recognizable tumour, a correct diagnosis was made six months before death, chiefly from the constant and marked presence of lactic acid. Within eleven months ten such cases were seen without recognizable tumour, all of which gave a positive reaction with Uffelmann's test, and yet no such reaction was ever observed in cases of gastrectasis or of chronic gastritis with absence of free hydrochloric acid. The author lays stress on the importance of early diagnosis in regard to the question of possible removal. Lastly he refers to the new test proposed by Boas for lactic acid in the stomach contents (*Epiteome*, November 4th, 1894, par. 364.)

Ozzena.

Dr. Stein obtains in ozzena most remarkable results from painting the nasal fossæ with a solution of trichloracetic acid. The painting is done by means of a piece of cotton-wool steeped in a solution (one-tenth per cent.) and fixed on the point of a flexible wire. The operation is done three times daily for the first few days and then once a day. The strength of the solution is gradually increased.

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

IN THE TEXAS SANITARIAN

for June, Dr. J. H. Sears, in his annual address as President of the Texas State Medical Association, spoke of the *History of Medicine in Texas*, giving a very vivid description of the life of a physician in Texas half a century ago, and the changes which have taken place.

He then spoke of the increasing number of dishonest and untrustworthy men practicing medicine and surgery in the state, and appealed to his hearers to assist in the passage of a law restricting and discouraging this.

Hon. Clark Bell has an article on

Railway Spine

which he read before the National Association of Railway Surgeons.

The term, he says, when used, as its inventor intended, to mean a vague pathological condition of the spinal cord, usually not accompanied by external injury to the spine, but due to some incident of railway travel is inexcusable.

Quoting the definition of Erichsen he states that it has no definite meaning, may cover any subjective symptom at all, and stigmatizes it as an invention intended to help malingeringers to bleed corporations, and used for no other purpose.

Other papers in this issue are on "Prevention of Consumption," by Dr. R. M. Swearingen, and "Dress as a Factor in Diseases of Women," by Dr. E. C. Collins.

IN THE BRITISH JOURNAL OF DERMATOLOGY

for June is an article by Dr. Wallace Beatty on

Seborrhœa.

The article begins by quoting Unna's statement that the term seborrhœa is commonly applied to two totally different diseases; that "seborrhœa oleosa" is a hypersecretion of the sweat glands, and that there is no dry seborrhœa, or deposit on the skin, of firm products of sebaceous glands.

These dry seborrhœas he says are chronic inflammations of the skin.

His clinical description states that seborrhœic eczema usually starts at the scalp and there is a history of dandruff. It has predilections for such places as the junction of forehead and hairy scalp, the temples, ears, naso genial folds, around the mouth, intermaxillary region; interscapular region; axile; crurogenital regions; and the back of the hand, particularly between the metacarpals of the thumb and index finger. It is prone to show a yellow coloration, (due to increased fatty secretion,) tends to spread in a serpiginous manner, and is of three grades of severity, squamous, crusted, and moist or weeping.

The creeping mode of spreading, the effect of parasitides, and the finding of microorganisms lead to a belief in a parasitic origin.

The diagnosis depends on the mode of spread, from the head downward, on the finding of scaly spots—outposts of the dis-

ease, and the choice of certain localities, the yellow color and serpiginous character.

Unna mentions the frequent appearance of seborrhœic eczema in cases of syphilis, causing an itching, serpiginous eruption and calling for local as well as general treatment.

The author takes issue with Unna in regard to the secretion of fat by the sweatglands—he thinks this does not take place but that the fat comes from around the hair follicles, and bears no relation in quantity to the number of sweat glands. The vernix caserea, also, he thinks due to the sebaceous and not to the sweat glands.

The paper is accompanied by some plates showing the microscopic conditions seen.

The observations confirm the view that seborrhœa is a disease of the sebaceous glands and also that of Unna—that dry seborrhœa is an inflammation of the skin.

Dr. Alexander Morton writes of "Eruption following the Use of Oil of Sandalwood."

He describes a case, a man twenty-five years old under treatment for a fresh attack of gonorrhœa by injection of solution of chloride of zinc and, internally, twenty drop doses of sandal oil in capsules, three or four times daily. The gonorrhœa improved rapidly, but in the third week of treatment there was a sudden eruption on the trunk and lower limbs.

The eruption was of dark red spots, many purpuric, about the size of a split pea. Many coalesced.

These spots were quite smooth and scarcely elevated. The eruption was fairly symmetrical, more abundantly on the back than front and on the extensor than the flexor surface of the legs. No subjective sensation, no complaint arthritic pains, no constitutional disturbance.

The drug was stopped, and in a few days the eruption disappeared without desquamation and leaving a very slight evanescent pigmentation.

There are many reasons for believing that sandal oil is not adulterated with copallia and the author gives a series of these, and also, though this eruption resembled in appearance some of those due to copallia, it was unaccompanied by itching and did not appear until the second week of treatment, while a copallia rash is to be looked for in about eight days.

Erichsen stands almost alone among English authorities who believed in gonorrhœal eruptions and those described by him might readily be syphilitic, as diagnostic appearances are not given and this may be said of the descriptions of most foreign writers.

The great necessity for recognizing a drug eruption is emphasized by one or two cases mentioned.

Dr. W. Dale James describes a case of "Glycosuria from Taking Thyroid Extract." The symptoms disappeared on stopping the use of the drug and adopting a diabetic diet.

Dr. S. G. Stafford Taylor describes "Two Fatal Cases of Pemphigus."

PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M.D.

MEDICINE.

Hydrastinine in Uterine Hemorrhage.

Gottschalk, (*Brooklyn Med. Jour.*), says hydrastinine may be employed:

1. First of all, in those uterine hemorrhages which are traceable to a pronounced congestion of the uterus. To these belong, above all, the often very profuse menorrhagias of spinsteres, in whom there is no pathological change in the condition of the genitals. In some of these cases it is possible to obtain a permanent result, so that even after discontinuing the remedy the menstrual flow remains smaller.

2. Also in hemorrhages which have their pathological and anatomical cause in endometritis, hydrastinine will lessen the quantity of blood, but here, according to Gottschalk's experience, the action is only palliative, not being sufficient alone to cure the local cause of the trouble.

3. For prophylactic or intermenstrual use, hydrastinine is useful before or during the first returning profuse menstruation after an abrasion of the uterine mucosa. It is well known that this menstruation, occurring after six weeks is often very profuse. In the very cases where there was a great loss of blood before the operation, it is of great importance to prevent further profuse hemorrhage. This is possible if the treatment with hydrastinine is begun several days before the expected menstruation, and, if necessary, continued during the duration of the menstruation.

4. Menorrhagias caused by retroflexio uteri are best treated by correction of the malposition; but for cases of fixed retroflexion, where the reposition is not yet possible, hydrastinine is a commendable remedy.

5. Secondly, uterine hemorrhages, i. e. those caused by the changes of the adnexa and their surroundings—offer a large field for the successful use of hydrastinine. To these belong the menorrhagia and metrorrhagia with pyosalpinx, ophoritis, ovarian tumors and exudations. Of course the cause of the trouble is not influenced by the remedy.

6. Climacteric menorrhagias are much diminished by a faithfully carried out hydrastinine treatment.—*Canada Lancet*.

Treatment of Alcoholism by Strychnine Nitrate.

Breed concludes a paper in the *Medical News* of April 7, 1894, on this subject as follows:

1. That we have in this drug a remedy that actually, for a period as yet undetermined, removes the desire for alcoholic stimulation in the chronic inebriate, and that *without the least effort on his part*.

2. A remedy that removes the distress and gnawing at the epigastrium, so common upon the withdrawal of alcohol.

3. A remedy that tones up the nervous system, allays the insomnia, the flighty and other bad feelings in the head, the mental disturbances, and the tremulous agitation and uncertainty of voluntary motions due to the withdrawal of stimulants.

4. A remedy that brings back the appetite and general physical vigor in the body.

5. A remedy that temporarily transforms a wholly demoralized creature into a man.

6. A remedy that is of great value in acute attacks of alcoholism.

7. Incidentally, a remedy that is an exceedingly good and safe heart-tonic.

8. More than all, a remedy that exerts a moral influence upon the patient, giving him what he had before wholly lost,—to wit, hope, enthusiasm, self-confidence, and courage, where before was dependency, abandonment, and despair; a steady, straightforward gaze, and a bright, youthful expression of the eye, which replaces the shame-faced, snake-ing, apologetic air of total depravity of the chronic inebriate.

9. We have in the nitrate of strychnine not a remedy that will oblige a man to abstain from drink if he does not want to do so, and such subjects do not deserve one. From the results obtained by the gold cure, the silver-ash cure, the Keeley cure, etc., we may conclude that we have a remedy that is as efficient as any of these and much safer; a remedy, moreover, that is not secret, and can be used by men who know the action of drugs and can use them with discretion and safety to the patient.

Meat-Eating and Bad Temper.

Mrs. Ernest Hart, who accompanied her husband in his recent trip around the world, appears to come to the conclusion that meat-eating is bad for the temper. In the *Hospital* she says that in no country is home rendered so unhappy and life made so miserable by the ill-temper of those who are obliged to live together as in England. If we compare domestic life and manners in England with those of other countries where meat does not form such an integral article of diet, a notable improvement will be remarked. In less meat-eating France, urbanity is the rule of the home; in fish and rice-eating Japan, harsh words are unknown, and an exquisite politeness to one another prevails even among the children who play together in the streets. In Japan I never heard rude, angry words spoken by any but Englishmen. I am strongly of opinion that the ill-temper of the English is caused in a great measure by a too abundant meat dietary combined with a sedentary life. The half-oxidized products of albumen circulating in the blood produce both mental and moral disturbances. The healthful thing to do is to lead an active and unselfish life, on a moderate diet, sufficient to maintain strength and not increase weight.

—*Boston Medical and Surgical Journal*.

SURGERY.**Appendicitis.**

Dr. J. Wm. White in *Theapeutic Gazette*.

SUMMARY:

1. The explanation of the great frequency of inflammation of the appendix is to be found in the following facts:

(a) It is a functionless structure of low vitality, removed from the direct faecal current; it has a scanty mesentery so attached to both caecum and ileum that it is easily stretched or twisted when they become distended; it derives its blood-supply through a single vessel, the calibre of which is seriously interfered with or altogether occluded by anything which produces dragging upon the mesentery.

(b) In addition, there is almost always present a micro-organism—the *bacterium coli commune*—capable of great virulence when there is constriction of the appendix or lesions of its mucous coat or of its parieties.

2. The symptoms in a case of mild catarrhal appendicitis—general abdominal pain, umbilical pain, localized pain and tenderness on pressure in the right iliac fossa, vomiting, moderate fever, and slightly-increased pulse-rate—cannot at present with any certainty be distinguished from the symptoms, apparently precisely identical, which mark the onset of a case destined to be of the very gravest type.

3. It must be determined by future experience whether or not operation in every case of appendicitis, as soon as the diagnosis is made, would be attended by a lower mortality than would result from more definite symptoms indicating unmistakably the need of operative interference. At present such indication exists in every case if the onset is sudden and the symptoms markedly severe, and whenever in a mild case the symptoms are unrelieved at the end of forty-eight hours, or, *a fortiori*, if at that time they are growing worse.

4. It must be determined by future experience whether cases seen from the third to the sixth day, which present indications of the beginning circumscription of the disease by adhesions and which tend to the formation of localized abscesses, will do better with immediate operation with the risk of infecting the general peritoneal cavity, or with later operation when the circumscribing wall is stronger and less likely to be broken through. At present, operation is certainly indicated whenever a firm, slowly-forming, well-defined mass in the right iliac fossa is to be felt; or, on the other hand, when a sudden increase in the sharpness and the diffusion of the pain and tenderness points to perforation of the appendix or breaking down of the limiting adhesions.

5. In the beginning of general suppurative peritonitis, operation offers some hope of success. In the presence of general peritonitis with septic paresis of the intestines, operation has thus far been useless.

6. Recurrent appendicitis of mild type, like acute appendicitis, frequently results from digestive derangements. Several attacks may

occur followed by entire and permanent recovery, but it is as yet impossible to differentiate these cases accurately from those which do not tend to spontaneous cure. Operation is certainly indicated whenever the attacks are very frequent.

7. Chronic relapsing appendicitis is characterized by the persistence of local symptoms during the intervals and by more or less failure of the general health. It usually indicates operation.

8. In either the recurrent or the chronic relapsing variety operation should be advised according to the following indications formulated by Treves: whenever (1) the attacks have been very numerous. (2) The attacks are increasing in frequency and severity. (3) The last attack has been so severe as to place the patient's life in considerable danger. (4) The constant relapses have reduced the patient to the condition of a chronic invalid, and have rendered him unfit to follow any occupation. (5) Owing to the persistence of certain local symptoms during the quiescent period, there is a probability that a collection of pus exists in or about the appendix.

HYGIENE.**The Question of Disinfection of Apartments.**

Chamberland and Fernbach (*Revue Scientifique*) say: The disinfection of apartments that have been occupied by patients suffering from contagious diseases is of great importance. Experiments are being constantly made with the object of discovering a reliable disinfectant, free of destructive or noxious properties. While linen, clothing and bedding can be easily disinfected with steam, with or without pressure, the walls, ceiling and floor, are the great difficulty. Corrosive sublimate, besides being a dangerous poison, is not efficacious when the surfaces are not smooth. The essences, as shown by Ch. Chamberland are valuable antiseptics, but it requires several days before some pathogenic germs are destroyed. Peroxide of hydrogen acts better than ozone, and destroys the germs rapidly if applied with a spray, but it is expensive. From numerous experiments made on the *bacillus subtilis*, the *aspergillus niger*, the *torula cerevisiae*, the *typhoid bacillus*, and others, Chamberland, one of the distinguished directors of the Pasteur Institute in Paris, and his collaborator, concludes that chloride of lime in the proportion of ten per cent., at a temperature of 40° to 50° C., is the best and cheapest disinfectant.—*N. Y. Therap. Rev.*

BACTERIOLOGY.**Antiseptic Properties of the Oil of Cinnamon.**

Kyle (*Therap. Gaz.*) finds that in a strength of $\frac{1}{10}$ it prevents the growth of the germs suppuration and erysipelas after an exposure of not less than thirty minutes, those of tubercle, anthrax, tetanus and glanders require an exposure of at least two hours; typhoid fever between one and two hours, and Asiatic cholera from three to five hours. The effect produced upon the germs he believes to be

rather a suspension of activity than complete destruction, so that this cannot be regarded as a safe antiseptic for surgical work, though valuable for application to mucous membranes.

Germs in Agriculture.

M. Jean Danysz recently reported to the French Academy an ingenious method of ridding the country of small rodents which had become so numerous and destructive that it was impossible to produce any crop. Every acre of land furnished a home for thousands of these pests. The method adopted was to dissolve some gelatin cultures of pathogenic bacteria capable of producing an infectious disease in mice, then soaking a great number of small cubes of bread in this solution, and placing the bread near the holes occupied by the rodents, every day for three days in succession. Within two weeks after this method was adopted, scarcely a live mouse was to be found in the district treated. When the burrows of the rodents were opened, their galleries were found to be filled with dead mice.—*Molim Medicine*.

Bacilli Tuberculosis in Cigars.

Dr. Kerez (*Centralblatt fur Bacteriologie*), reports the result of experiments which he has been making for the purpose of determining the possibility of the communication of tuberculosis through the medium of cigars. It is a well known fact that cigar makers are in the habit of making the leaves adhere to the cigar by moistening them with saliva from their own mouths. The force of habit leads them to continue this practice, although in recent times manufacturers provide their workmen with materials for the purpose indicated. Dr. Kerez made cigars by moistening the leaves with saliva known to contain tubercle bacilli. The cigars were then dried and packed away in boxes in the usual manner. It was found afterward, when the cigars were unrolled and the leaves washed in water, that the infusion thus obtained, having been injected in guinea pigs, produced consumption, clearly showing that cigars may thus be the means of communicating tubercle bacilli and giving rise to pulmonary disease.—*Journal of the Med. Sci.*

OBSTETRICS.

The Placenta in Uterine and Tubal Abortion.

Pilliet (*Progrès Medical*), has studied two distinct cases of tubal abortion and compared them with many other reported instances of this condition. The chief characteristic of tubal abortion is its incompleteness. After the destruction or expulsion of the fetus portions of placenta remain attached to the tube and continue to develop. The same occurs in many cases of early uterine abortion, hence placental polypi or tumors—"placentoma" or "deciduoma"—develop. Dropped hydatidiform chorionic villi, representing an abortion several years past, have been re-

moved from the uterus with the curette. But the parasitic remains of the placenta are far more commonly seen, if not constant, after tubal abortion. In tubal gestation ending in abortion small hemorrhages set in, then a free flow, corresponding to the expulsion of part of the ovum. Slight oozing follows, then the tube fills gradually, and at last another considerable loss of blood occurs. The presence of a piece of placental tissue explains this phenomenon. When, therefore, after a loss of blood resembling in clinical history an abortion, a tube remains enlarged and tender, and, when uterine hemorrhages continue, without complete return of the tube to its normal proportions, tubal gestation, and incomplete abortion may be diagnosed. Hence an operation is indicated to anticipate the risks of intraperitoneal rupture. The persistence of portions of placentas after abortion appears easy to explain. At term the blood sinuses of the uterine tissue have widened and coalesced so as to form a single layer of blood between the maternal and the foetal structures. Hence complete detachment of the placenta is easily effected. In abortion the above-named condition has not developed, detachment becoming more difficult. In tubal abortion the placenta becomes closely united to the tubal wall, which cannot undergo the complicated changes that occur in the uterine tissue in normal pregnancy.

ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM JULY 7, 1894, TO JULY 14, 1894.

Captain George McCreery, Assistant Surgeon, will be relieved from duty at Fort D. A. Russell, Wyoming, by the Commanding Officer at that post and will report for duty at Fort Washakie, Wyoming.

First Lieutenant Frank T. Meriwether, Assistant Surgeon, will be relieved from duty at Fort Logan, Colorado, by the Commanding Officer of that post and will report for duty at San Diego Barracks, California.

Major Augustus A. De Loffre, Surgeon U. S. Army, Fort Logan, Colorado, is granted three (8) months leave of absence, with permission to go beyond sea.

Captain James D. Glennan, Assistant Surgeon, now on leave of absence, will report without delay to the Commanding General, Department of the Missouri for temporary duty.

Major Egon A. Koerper, Surgeon, granted leave of absence for one month on Surgeons Certificate of Disability.

The leave of absence for seven days, granted Captain Paul Clendenin, Assistant Surgeon, is extended twenty-three days.

NEWS AND MISCELLANY.

The St. Louis *Clinique* has passed into the hands of Dr. Emory Lanphear, Professor of Surgery in the College of Physicians and Surgeons. Dr. Lanphear will conduct the journal in the interests of that school, and of the medical profession of the West.